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Recovering normal: A qualitative study of grief following bereavement

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ABSTRACT

This thesis explores the notion of 'recovery' from grief following bereavement and answers the question, what happens when people 'fail' to recover? Researchers and practitioners promote a linear, staged, 'normal course' of grief, yet people who fail to follow this course are understood as experiencing 'complicated grief': a form of psychiatric disorder. In particular, the thesis explores the debates and issues around the highly contested notion of recovery from grief, drawing on an analysis of the theory and policy of grief and recovery, and empirical qualitative interview data from bereavement care practitioners and bereaved people in England. Arguing for the acknowledgment of the experience of 'non-recovery', this thesis draws on a Foucauldian approach to problematise the notion of recovery, highlighting how 'recovery' is a socially constructed notion linked to the individualised vision of health and happiness promoted by neo-liberal governmentality.

The study concentrates on three areas: the political and cultural factors that 'frame' grief and recovery in England; how grief is managed, through the example of bereavement counselling, and the ways in which bereaved people make sense of grief. The findings of this study present the experience of grief as one of navigating a 'liminal space'. Recovery from grief was achieved or resisted through the negotiation of a variety of political, medical and social discourses. These discourses provided guidelines for the bereaved person, where they were encouraged to make sense of grief, engage in certain practices and work towards the building of new identities, in order to recover from grief. Further, through the incorporation of 'non-recovery' this study proposes an alternative way of theorising grief, arguing for the need to emphasise the relational and embodied aspects of grief.

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CHAPTER 1

Introduction

This thesis examines the notion of recovery from grief following bereavement. I explore the concept of recovery and how it frames the theory, policy, and practice of bereavement care, and the lives of bereaved people in England.

The origins of this study arose from three separate debates within bereavement care and mental health care. First, within bereavement care and practice I noted how the term 'recovery' was increasingly contested or rejected, epitomised in a special issue on the use of recovery in the *Death Studies* journal (Volume 32, Issue 1, 2008). Second, I observed a growing interest in recovery within UK national health care services, particularly mental health, where service users and providers were embracing a 'recovery model' of care. Third, 'complicated' and 'prolonged' forms of grief were increasingly a focus of psychiatric classification, becoming a concern for both bereavement care and mental health care, and producing a burgeoning field of research into 'complicated grief' (Prigerson et al., 1995, 2009; Shear, 2010).

These debates heralded the contested nature of the ways in which grief and recovery were being conceptualised and practiced. Within bereavement research and practice, grief was commonly understood as 'normal' and 'natural' and not something from which one recovered but rather something that one lived through. Yet the rising focus on 'complicated' forms of grief suggested there were times when grief was 'derailed' from its natural course (Shear, 2012). There was thus a growing theme in grief research of measuring abnormal forms of grief, suggesting that in some cases people 'fail' to progress through grief to recovery. Largely the researchers who were

articulating these debates were psychologists and psychiatrists, who maintained an understanding of recovery from grief as something to be managed and measured in the individual psyche. This dominant notion of recovery failed to incorporate the shift towards social understandings of grief, as demonstrated by work across the social sciences (Hallam et al., 1999; Hockey et al., 2010; Klass et al., 1996).

It was amid these disputes and contradictions that I developed this thesis, taking 'recovery' as my focus, from which to examine how the boundaries around what constitutes successful grieving were being drawn. With a background in sociological theory, I turned to theories and research from across the social sciences and cultural studies to critique the dominant notion of recovery and work towards an alternative understanding of grief. My aims were formulated from an interest in finding out how recovery and the failure to recover were being negotiated: in bereavement care practice and by those who experience bereavement. In order to address these aims I undertook a qualitative approach using data from semi-structured interviews both with bereavement care practitioners working across England and people who had been bereaved, to gather insight into how recovery and definitions of 'complicated grief' were expressed in practice and experienced in the lives of bereaved people.

In what follows I describe the professional and personal motivations that led me to research the contentious term 'recovery' and its relevance to grief and bereavement research and practice. I explain how I was led to the alternate notion of 'non-recovery' that informed my aim to uncover what happens to people who 'fail' to recover.

1.1 Recovery and grief: conflicting perspectives

In 2008 the journal *Death Studies* published a special issue on 'recovery from bereavement'. The special issue was in part a response to an article written by Balk (2004) in the same journal that addressed how bereavement researchers and practitioners considered the terms 'recovery' and 'recover' as 'problematic' and actively discouraged their use. Balk (2004) described how researchers and practitioners favoured other terms such as 'manage', 'adapt', 'deal with', 'adjust' over recovery. Balk provided two accounts from his personal and professional experience to illustrate the 'unseemly' nature of recovery from bereavement. He detailed his experience of including the phrase 'recovery from bereavement' in a manuscript only to have it returned from the reviewer with the suggestion that the usage of such a phrase was counter to 'current thinking in bereavement research'. Balk also recounted a conversation over lunch with psychiatrist Colin Murray Parkes¹ who expressed regret over the title of his co-authored book *Recovery from Bereavement* (Parkes & Weiss, 1983). I contacted Parkes to clarify this remark and he replied that on reflection he did not think *Recovery from Bereavement* was a bad title but that recovery pinned down something and made it simple: 'it promises an ending, a solution to a problem that cannot be solved, or not completely'².

In the article Balk expressed puzzlement at the dislike of the term 'recovery' proposing that on the contrary it was 'belittling' to insist that people were unable to recover from grief. Balk referred to the dictionary definitions of recovery, to suggest recovery has much broader meaning than that associated with the medical definition

¹ Parkes' research on grief heavily shaped the nature of bereavement care as described in Chapter 2.

² Personal email communication, 7 May 2016.

of recovery, which implies a return to prior functioning, and further positions grief as an illness - a notion repellent to bereavement researchers and practitioners. Balk referred to the Oxford English Dictionary, which defined recovery as 'the cure or healing of an illness, wound, etc' and also 'the restoration of a person (or more rarely, a thing) to a healthy or normal condition, or to consciousness'. For Balk, recovery did not refer to the retrieval of the lost person, or a prior way of life, but to the recovery of one's self, 'one's humanity'. Balk suggested this recovery of the self following bereavement was through 'redefining' and 'reintegrating' into life.

Four years later in the dedicated special issue Balk (2008) similarly contended that it is 'nonsense' to reject recovery, and that the 'usual' outcome of bereavement is recovery, claiming it is 'obvious' bereaved people 'typically recover'. Balk again described the 'widespread resistance' to using recovery in bereavement, and the 'distaste' towards recovery that is 'at times visceral'. He also acknowledged the rise in popularity of the term 'resilience', across a variety of mental and physical health concerns, and its preferred use over recovery, which Balk found 'ironic' due to the definition of resilience being 'to recover quickly'. One of the main proponents of the theory of resilience during bereavement, Bonanno (2009), argued that rather than following a trajectory of recovery, people display resilience in the face of adverse events, maintaining a sense of mental equilibrium. For Balk, the notion of resilience and the belief that people 'bounce back' from bereavement was against the understanding that people experience 'growth' through the process of grieving. Accordingly, if one's self and world is resilient and has not been devastated and challenged by bereavement, there is nothing to grieve and from which to recover.

In the remainder of the special issue on recovery the authors suggested alternatives

to recovery, including resilience and 'adaptation'. Rosenblatt (2008a) took a different perspective by exploring how recovery has different meanings and plays different roles depending on the context. Instead Rosenblatt suggested recovery should be viewed as a metaphor that highlights some things and obscures others. Metaphors are a term of language that compare a literal experience with a figurative concept, in order to suggest a resemblance, or as a way to represent an experience. Influenced by Rosenblatt's suggestion, I too began to feel that recovery as a metaphor was being used as a 'figurative' concept to describe the 'literal' experience of grief, and that as a metaphor, recovery was obscuring more issues than it was highlighting. It was clear that there was a hesitancy, and as Balk described at times, an almost 'visceral distaste' for using the term recovery in reference to grief. However, it was precisely the contested nature of the term, and increasing preference towards 'resilience', that meant exploring the notion of recovery felt like an important area of inquiry. I now detail some of the personal motivations that led me to question the meaning of recovery from grief.

1.1.1 My own 'recovery'

Embarking on this research, investigating the meaning of recovery caused me to reflect on my own recovery. Before beginning the PhD research I had focused my research on the experience of grief (Pearce, 2008, 2010, 2011). My initial interest in exploring grief and bereavement in academic research stemmed from a personal experience of bereavement. In one respect my motivation for reflecting on grief through the assistance of academic theory was a way to make sense of the experience when other methods had failed. This process of making sense of my own experiences was explicit in my first publication based on my undergraduate degree dissertation

(Pearce, 2008). At the time I was influenced by writings that described the healing power of voicing one's narrative of trauma (Bury, 2001; Charmaz, 1999; Gilbert, 2002). I contended, and believed, that in voicing my own experiences I had resolved the rupture in identity caused by grief and recovered my 'self', an argument not dissimilar to Balk's understanding of recovery described above.

According to models of grief as a staged process, I was 'recovered' and had successfully returned to 'normal' functioning. Yet I also knew that my 'recovery' was something in flux and was constantly renegotiated. Furthermore, I certainly was not keen on describing my life as one of recovery or not, which I felt meant my life was determined by events that had happened before I was 16 years old. In my earlier research, as I began exploring the literature around grief, I was dismayed by articles that claimed young people bereaved of their parents were in effect destined for an array of mental health problems; from depression and addictions to having intimacy problems (Gray, 1987; Harris, 1991; Harrison & Harrington, 2001; McLeod, 1991; Raphael et al., 1990). When I stopped taking it too personally I decided to explore the experiences of other young women. In the data from the six participants, I discovered a variety of responses and ways of managing grief that I argued were marked by an ambivalent tie to their deceased mother (Pearce, 2011).

The presence of a continuing ambivalence in the young women's relationship with their mothers resonated much with my own feelings towards my deceased mother. The presence of an ambivalent bond did not fit easily into understandings of grief that suggested a movement through stages and a time limit to grieving, which I expand on in Chapter 2 in my detailed review of the grief literature. Rather ambivalence revealed a back and forth movement with no clear resolution: a double-bind.

Personally, acknowledging ambivalence meant realising the idea of recovering the self was not only impossible but also relied on an inaccurate understanding of what constitutes the 'self'. The self as revealed through ambivalent ties, rather than an autonomous individual, was relationally formed and socially constructed. The discovery of ambivalence was the starting point for the current investigation into recovery from grief, where, as I demonstrate throughout this thesis, ambivalence served to counteract the narrative of recovery and also brought into question contemporary understandings of grief.

1.1.2 A recovery movement

As I moved away from my own experience of recovery, I learned of the considerable growth of interest in the concept of recovery in mental health care (Department of Health, 2001; McPherson et al., 2009). Stemming from a *mélange* of beliefs and values that emerged from anti-psychiatry, the psychiatric survivors movement, and the consumer rights movement, recovery began as a radical movement, that critiqued the paternalistic nature of health care and sought to reclaim power back to the patient or service user (Braslow, 2013; Roberts & Wolfson, 2004; Travis, 2009). The move towards recovery sought to bring acceptance to living with a mental illness and to broaden the notion of recovery outside of medical requirements. The introduction of recovery into health care policy was an attempt to remedy what is considered to be the 'epistemic injustice' at the heart of the way health care services have been administered (Carel, 2013).

Arguably, as recovery began to be co-opted and incorporated into mainstream practices, radical demands coincided with, or indeed were diluted by, a government

agenda of autonomy and individual responsibility (Braslow, 2013). This was perhaps a result of the 'plastic' nature of recovery that was designed to be inclusionary unlike the exclusionary nature of the healthcare of the past. As I describe in Chapter 5, service users began to express their dissatisfaction with a notion of recovery that had come to be shaped by government directed outcomes rather than being individually defined. It appeared that implementing a recovery model in mental health was beginning to experience similar troubles to defining recovery from grief in bereavement care. What was being established were two dividing notions of recovery, one that could be decided from a clinical perspective, and that had to be proved to have universal application; and one that was defined individually and that could reaffirm, resist or be completely detached from normative beliefs around recovery. However, neither of these definitions of recovery incorporated a socially informed model of recovery, for instance one that emphasised how recovery was achieved by being in relation to certain ideas, people, organisations, rather than simply being a matter of individual choice and will.

The recovery movement was complemented by a government agenda focused on individual happiness and well-being. In 2010 the UK government set out to measure the population's level of happiness, in the belief that happiness and well-being was an indicator of national progress in the same way as gross domestic product (GDP). Policies were created to directly target and improve well-being, through schemes that aided access to psychological therapies (Improving Access to Psychological Therapies) and enabled people to recover from depression. Through government driven initiatives, improving one's well-being and recovering from mental illness were understood as a matter of individual choice and responsibility, as was the trend in public health. In such a climate, focused on improving happiness and human

flourishing, 'negative' emotions like grief, and mental disorders like depression, became things not to live with but to overcome, not only in the name of individual health but also for the economic stability of the nation. As I discuss in Chapter 5, a thriving economy is key to many mental health reforms due to the huge financial costs of mental health within the National Health Service (NHS) budget, estimated at an annual cost of £105 billion in 2016.

In this thesis, I discuss how people are politically and socially obligated to recover from grief. I illustrate this through exploring the question of what happens when people fail to recover. The question of what it means to not recover is what I asked myself when confronted with the variety of conflicting discourse around recovery. Debates over how best to define recovery are divided between a deep attachment to recovery, and an equally strong aversion to not recovering. I argue that this is because of what not recovering represents and the threat it poses to ideas about grief and the person who grieves. Failing to recover from grief reveals the difficulties people have in 'detaching' from deceased people, blurring the modern divide between life and death (Howarth, 2000). Further, in a climate where mental distress is construed as a heavy 'burden' not recovering from grief presents a problem to the political and economic running of society.

1.1.3 What is non-recovery?

In exploring the possibility of not recovering, or rejecting dominant notions of recovery, I returned to an essay by Kauffman (2008), also included in the *Death Studies* special issue on recovery. Kauffman's essay was entitled: 'What is "no recovery"?''. Kauffman's article drew on philosophical and clinical insight to suggest

that following bereavement, no one recovers. Kauffman suggested, 'no recovery' was not a transitional state but a condition of human existence. In such a state one might claim recovery if he or she finds that they can adapt to such conditions, but for Kauffman this was only a display of social adjustment not a resolution of mourning. Often theories of grief sought to give grief a function whether enabling social cohesion or an opportunity for social transformation. Kauffman's state of no recovery suggests that no norms are sufficiently adequate to take care of the disruption caused by death, and so recovery becomes a moral or symbolic act, put simply a socially-framed performance.

Kauffman's essay provided a concept to explore: the question of no recovery, which I refer to in this thesis as 'non-recovery'. In exploring the possibility of non-recovery, recovery appears as only one way to respond to grief. It opens the ways to explore how recovery might instead be a socially informed and constructed performance. In order to conceptualise the possibility of 'non-recovery' I have drawn on van Gennep's (1960) and Turner's (1969) use of the concept 'liminality'. In this thesis I describe the experience of grief as one of inhabiting a liminal space. I suggest that within this liminal space the bereaved person is searching to make sense of and manage grief, negotiating the ideas, norms and discourses around grief and recovery, following a trajectory of 'recovery' or 'non-recovery'. The growth of interest in the psychiatric categories of 'complicated grief' and 'prolonged grief disorder' provide clear classifications of what constitutes 'abnormal' or 'problematic' grieving in contemporary research and practice. The emergence of the 'complicated griever' supplied an empirical example to examine the contested boundary between recovery and non-recovery. The ways in which recovery from grief comes to be constructed, defined and managed thus became the focus of the thesis.

1.2 Aims of the thesis

I have detailed how the aims of the thesis were structured around exploring the notion of recovery following bereavement in theory, policy and practice in England. I recognised that because recovery is a contested term in bereavement care practice embarking on a study of this was potentially controversial. However, I argue that an examination of the notion of recovery from grief is required in order to unpack some of the implications that surround the contested views on recovery for research and practice, as well as to challenge the assumptions that underpin grief and bereavement and also for the benefit of the person who experiences bereavement.

In bereavement research and practice, grief is understood as the subsequent natural emotional response that emerges following bereavement. In this thesis, I use the term bereavement to refer to the event of losing someone from death. I refer to grief as the emotion or feelings that arise in response to bereavement. This distinction between the event of bereavement and the response of grief is important for I contend in this thesis that though bereavement is an event which befalls many, grief as a response can be felt, expressed, and managed differently.

In seeking to highlight the shortcomings of the way grief is currently theorised, and shed light on the possibility of 'non-recovery' and the person who 'fails' to recover, I turn to the work of Foucault (1961, 1963, 1970, 1975) who consistently critiqued the normative understandings of ideas, practices and subjectivities by highlighting how ideas about society and people are constructed through 'discourses', and identities are produced at the intersections between discourse and practice. Focusing on

discourse involves analysing how certain ways of describing and practising ideas, people, or experiences, dominate in a particular historical context. Foucault analysed how certain ideas come to be governed by focusing on 'problematisations': how certain people, ideas, and practices come to be considered 'problematic' at key points in history in certain societies or cultures, and the strategies used to manage them. My aim was to analyse the bereaved person using this framework, to explore how grief had become a problem through the dominance of discourses of recovery, shaping grief and the bereaved person as something to be managed. Within this was the subsequent aim of bringing alternatives to recovery into view, an aim demonstrated in Foucault's work through critiquing the 'figure of man' that western thoughts had relied upon. My aim was thus to bring to light the shape of the 'non-recovered' figure through revealing the ways in which current theories of grief and recovery were formulated around a particular vision of the bereaved person, that had highlighted and obscured different aspects of grief and the bereaved person's experiences.

The aims of the thesis are:

- To consider the implications of the broader move within mental health care towards recovery for grief and bereavement care.
- To give insight into how recovery following bereavement is defined and managed in current policy and practice.
- To provide empirical data on what happens when people are seen as failing to recover from bereavement; when someone's grieving behaviour is categorised as 'complicated', 'complex' or 'prolonged' as well as giving voice to the narrative of 'non-recovery'.
- To add to the body of social literature on alternative ways of theorising grief

and bereavement that incorporates the idea of non-recovery.

To carry out these aims I adopted a qualitative approach to research. I conducted an analysis of a variety of documents relating to how people make sense of and manage recovery and grief in a contemporary UK setting. I drew upon government policy documents from 2001 onwards; literature from bereavement care organisations; and lay literature on grief, such as first person memoirs. Following this I carried out 27 semi-structured interviews with both practitioners working across a variety of organisations delivering bereavement care and support and with people who had experienced bereavement. The data draw on interviews with people working within organisations such as the national bereavement charity Cruse Bereavement Care, a local bereavement counselling service and the non-profit organisation Grief Recovery UK.

1.3 *The structure of the thesis*

In the next chapter I review the literature on grief and bereavement. I move chronologically beginning with Freud's (1917) essay 'Mourning and Melancholia' up to the present day debates concerning 'complicated grief' and 'prolonged grief disorder'. I argue that the dominance of psychological studies into grief has transformed grief into a problem of the individual psyche, necessitating the creation of bereavement counselling and therapies. I explore the type of assumed subject that the psychological view rests on, questioning its validity. In Chapter 3, I critique the psychological notions of grief and the bereaved person by exploring other literature on grief, in particular taking a different angle on Freud's understanding of mourning

and melancholia. I argue for the need for grief researchers to look beyond the psychology of grief into the study of emotions and affect to suggest an alternative multidisciplinary way of theorising grief. I introduce the concept of 'affective practices' to explore how grief can be both an individually felt and socially practiced emotion. In Chapter 4, I outline my methodological approach indebted to the methodology of Foucault, and how I utilised his ideas to focus on the 'problematisation' of grief, and critique the essentialising of grief and subject. I also detail the methods I used and provide background to the participants of the study. Chapter 5 details the cultural and political framing of grief and raises issues about how grief and recovery are framed and shaped by a variety of social, political and economic factors such as psychiatric diagnosis, literary narratives, economic policy on happiness and well-being and the growth of a 'recovery model' in mental health care. This sets the scene for Chapter 6 in which I describe the role of bereavement care services in England through an examination of bereavement counselling. I present the data from the bereavement care participants, exploring what 'grief work' involves and how recovery is negotiated in practice. In Chapter 7, I draw on the interview data from the bereaved participants, analysing how they described the experience of grief, how they managed grief and the sense of self-identity they narrated. In Chapter 8 I synthesise the key themes of meaning, practices and identities that emerged from the data before drawing together the final conclusions and implications for practice in Chapter 9.

CHAPTER 2

Literature review

2.1 *Introduction to the chapter*

In this chapter I review the key thinkers and theories that have populated the field of grief and bereavement research over the last century. This review begins chronologically to provide a brief history of the ideas that have sought to make sense of grief, from a largely western, psychological perspective, into what has evolved into the expansive field of the study of grief and bereavement. I aim to show how some theories and models such as the work of Kübler-Ross (1970) and the five stages of grief remain popular to this day, while others either lost favour or suffered from misinterpretation over time.

The work of Freud (1917) is an exemplar of the latter case and is commonly where most literature reviews of grief and bereavement begin. However, I argue that the largely psychological field of contemporary grief research has inherited and reiterated overly simplistic renderings of Freud's writings in 'Mourning and Melancholia' where definitions of successful mourning are often still considered to be about 'letting go' and 'detaching' from the deceased. The dominance of psychological understandings of grief has, I demonstrate, led to particular ways of understanding grief as an individual, internal emotion. Crucially it configured recovery as a psychological process with various stages and tasks to 'work through'. To contrast I highlight the work of sociologists and anthropologists who critiqued this linear process view of grief and recovery by demonstrating the cultural variations in

understandings and practices of grief and mourning. From this work has emerged the 'continuing bonds' thesis of grief (Klass et al., 1996) and an interest in the stories of bereaved people which its proponents argued was a more accurate means to capture how people actually experience and recover from grief (see, for example, Walter, 1996). I also discuss research into grief informed by the work of Foucault (Árnason, 2001, 2007; Árnason & Hafsteinsson, 2003; Foote & Frank, 1999) to demonstrate the ways in which changes in theories of grief and recovery can be viewed alongside transformations in government rationality, where the aim of grief theories and practices is the production of autonomous individuals. In closing I consider the paradox that lies at the heart of grief theories and practices, that of the formation of a subject who is simultaneously autonomous and independent and yet liable to devastation at the death of another.

2.2 *A brief history of the study of grief*

2.2.1 Freudian beginnings

The academic study of grief is a relatively modern phenomenon with systematic research on death and dying only emerging in the aftermath of the Second World War (Small, 2001). The study of grief and its expression was previously the domain of the arts and literature (Archer, 1999). The publication of Freud's essay 'Mourning and Melancholia' in 1917 is considered as the first attempt at a 'scientific' understanding of grief, though Freud himself acknowledged his thoughts were not a claim to general validity and that the empirical material upon which the study was founded was 'insufficient' (Freud, 1917, p. 243). In his essay, Freud sought to delineate the nature of the state of melancholia by comparing it to the condition of mourning. For Freud

the states of both mourning and melancholia shared the same causal influence: that of the loss of an object. The lost object was not only the loss of a person but could also be 'the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on' (p. 243). Melancholia was not strictly the consequence of failed mourning as it came to be understood in later research but rather that in both cases loss was the 'environmental influence' yet this loss could be entirely abstract. Melancholia was characterised by:

A profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. (Freud, 1917, p. 244)

The same traits were to be found in mourning aside from a disturbance in self-regard. What happened in melancholia was that the reproach one might feel towards a lost object was, in the absence of the object, turned inward appearing as a reproach against oneself, or in Freud's terms against one's ego. Freud viewed the psyche as structured into three parts: the 'ego', the 'super ego' and the 'id'. The 'id' refers to the unconscious drives, composed of the life and death instincts. The life drive includes the 'libido', which is often interpreted as referring to love or desire. The ego is the rational response between the id's unconscious urges and the societal norms and demands. The superego's function was to control the instincts of the id by incorporating the moral values of the society in which one is situated, learned from parents and others. The reproach one felt towards the other person that in their absence was turned against one's self, was an action of the 'libido'. The libido is

always seeking out new connections. It is this belief that led Freud to suggest that the frustration of a desire caused by the absence of the object of desire turns back on to the person's ego, overwhelming it and causing a shadow of the object on the ego.

This understanding of how attachments and desire work framed the way Freud understood successful mourning. This was through a long and painful process of 'reality-testing' where 'each single one of the memories and expectations in which the libido is bound to the object is brought up and hyper-cathected' leading to a detachment of the libido so that the 'ego becomes free and inhibited again' (p. 245). To understand the implications of this process there is a need to unpack some of the terms Freud used as well to put his ideas into the context of the rest of his work. First of all, 'reality-testing' involved recognising which aspects of the self were located in the dead person and retrieving them to better understand oneself. By contrast in melancholia one does not know what she or he has lost: 'one cannot see clearly what it is that has been lost, and it is all the more reasonable to suppose that the patient cannot consciously perceive what he has lost either' (p. 245). Melancholia is brought about by the inability to recognise not that someone has died but what she or he has lost in him or herself: 'he knows *whom* he has lost but not *what* he has lost in him' (p. 245). The distinction then is that in melancholia what has been lost is withdrawn from consciousness, whereas in mourning nothing about loss is unconscious.

As I outline below, later theorists construed this to mean melancholia or the failure to mourn was largely caused by an inability to face the reality of the death. However the question caused by the condition of melancholia: what it is that has been lost, also seeks the extent to which parts of the self, or ego, have been lost. Why this process is so difficult and prone to failure is because of the way in which objects of desire – a

person or a perception of a person – become incorporated into oneself through a process Freud described as ‘identification’. For Freud all love relationships were fraught with ambivalence due to the way in which identification with an object meant the sustenance of one’s existence was at least in part reliant upon the continuation and endurance of another object outside of oneself. The loss of the loved object thus brings that ambivalence out into the open, to be managed laboriously or experienced as a reproach towards oneself.

Klein (1940) further developed Freud’s thoughts on mourning and melancholia, to understand mourning as the experience of losing one’s internal ‘good’ objects. For Klein the success of mourning in later life was dependent on how well the infant identified with a stable good object, which is in the form of the primary caregiver, and how these objects were internalised. This process of identifying with an external object was crucial to the stability of the ego and its capacity to integrate experience. The loss of a loved person is one where the mourner feels he or she has lost their internal good objects as well. As Klein describes, ‘[h]e then feels that his internal ‘bad’ objects predominate and his inner world is in danger of disruption’ (p. 353). Normal mourning seeks to reinstate the object as well as the internal objects that have been felt to be lost, therefore recovering what has been already attained in childhood. Melancholia results when the experience of losing one’s internal objects was not completed in childhood. The melancholic mourner fails to rebuild the disintegrated inner world and re-own the ‘projective identification’ that was lodged in the now deceased person.

For Klein and Freud, objects were mental images of a loved other that become internalised into the person’s sense of self. Objects were not representative of the

whole person but rather parts of the other that maintained and sustained the person's own self. Klein made the further distinction of recognising that objects can be 'good' and 'bad'. Furthermore, in Klein's theory it is possible to understand how objects go from good to bad in the event of bereavement. The melancholic figure is not then just holding on to lost objects but overwhelmed by bad objects, in part according to Klein because the first mourning was not completed.

In the theory of Freud and Klein, responses to bereavement, whether described as mourning or melancholia, are seeking to reconcile with the same problem: the loss of a loved object. It is only that those expressions take different guises but are not inherently pathological. One reason why Freud might contend mourning is necessary is his understanding of the 'life drive'. In brief, the life drive is what impels the ego to preserve life – being alive – at all costs. Severing attachments to a dead object is thus more about the drive of the ego that is now faced with deciding 'whether it shall share this fate' (p. 255). Mourning then is about the success of the life drive, of the ego, but this seems to leave unanswered why precisely the libido goes about directing its energies onto objects. The libido is formulated both as an energy independent of objects in which it can invest or divest itself whenever necessary and also as something that derives pleasure from, and is reconfigured by, the process of attaching to objects itself. So there's a contradiction in Freud but this is not Freud's contradiction alone. The paradox of why people form relationships only to have to mourn them is one that faces understandings of grief more generally, and one that, as will be demonstrated, has sought to be resolved through a variety of perspectives.

I return to Freud in the next chapter to discuss feminist interpretations of Freud that utilised his ideas quite differently. What remains important to mention here is that

certain interpretations of Freud became the basis on which later work on grief was established, either affirming or rejecting his claims. Other academics have noted this disservice to Freud, as Small (2001, p. 25) argued, 'simply to talk about letting go and moving on (...) does not do justice to the idea of resolution presented by Freud'. Further, many have gone to pains to emphasise that Freud's intimation into what might be happening was not necessarily an invitation to do something about it (Granek, 2013; Small & Hockey, 2001). In fact intervention into mourning was clearly opposed: 'We rely on its [mourning] being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful' (Freud 1917, p. 244). The question I will seek to address in the rest of this chapter is why certain interpretations have survived and what or in whose interests they might serve.

2.2.2 Grief as a syndrome

Whether influenced by Freud and the burgeoning community of psychoanalytic practitioners or as a consequence of the mass deaths suffered in the First and Second World Wars, the inter-war period saw an increase in research interest in grief that proposed categories of adjustment (Eliot, 1932) and began to describe the process of grief, as well as focusing on recovery from war bereavement (Fulconer, 1942). Lindemann (1944) is commonly credited as carrying out the first systematic and empirical study of grief. In 1944 Lindemann published his article 'Symptomatology and management of acute grief'. The article was based upon 101 interviews he carried out largely based on 'psycho-neurotic' patients who were bereaved during their treatment, as well as relatives of hospital patients. Lindemann also spoke to survivors of the Coconut Grove nightclub fire in Boston in 1942. Lindemann's work is notable for the fact he described grief as a distinct syndrome with its own

symptomology. Lindemann described grief as a universal syndrome that could be known and measured involving symptoms such as somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and loss of patterns of conduct. What Lindemann's work sought to prove was thus a normal course of grief from which abnormal grief could be identified. This allowed for grief to become a matter to be dealt with by psychiatry that could aid people along the 'right' course. In fact Lindemann was quite clear that grief was something only psychiatrists could assist with (Granek 2013, p. 59).

Establishing grief as a definite syndrome also had implications for what was considered a successful recovery. Grief required work and psychiatrists were encouraged to monitor whether people did the appropriate grief work, where grief work was understood as involving 'efforts at extricating himself from the bondage of the deceased and finding new patterns of rewarding interaction' (Lindemann, 1944, p. 147). Echoes of Freud are clearly audible in this interpretation of grief work as implying a willing detachment from the deceased person, but Lindemann also emphasised the need to identify 'delayed' or 'absent' reactions to grief. Here Lindemann introduced the element of time into grief and its recovery, where grief was comprehensible as something that occurred and dissipated in a set time period. This also justified the need for intervention where the gaze of the psychiatrist could both identify and measure a person's movement along the now established normal course of grief.

Lindemann's research has since received criticism for the weakness of his methodology and lack of analysis. For example Archer (1999) points out that Lindemann derived much of his argument from the Coconut Grove survivor accounts

but they only made up 13 of the 101 participants. Methodological issues notwithstanding, Lindemann's work appeared to be driven by the ambitions of the psychiatric and psychological fields of practice at the time and the desire of both to establish themselves as scientific disciplines with procedures and classifications comparable to the rest of western medicine. Lindemann's work set forward an understanding of grief that subsequently became unquestioned, the idea of grief as distinct and measurable and involving a normal course from which any deviation was deemed to be abnormal. For some, grief becoming a matter for psychiatry and psychology provided new opportunities for research and practice, while in retrospect others, as Klass (2014) remarked, view Lindemann's study and its implications as contributing to a narrowing in understandings of grief in the twentieth century.

On the one hand the expanding fields of psychology and psychiatry were changing the way grief was understood and managed, positioning grief as an object for psychiatric concern. Another factor influencing the management of grief was the declining significance of religion in the UK. This was the contention of Gorer's (1965) study first published in 1955. Gorer's research is notable by its absence in psychological reviews of the literature, though with his anthropological inclinations that may be unsurprising. Gorer carried out a survey of 359 people in the UK, 80 of whom took part in qualitative interviews. What was apparent from the survey and interview data was that there was a lack of religious belief and ritual in how people experienced or dealt with their grief, leading Gorer to claim that people had lost the art of grieving. Gorer, however, in line with his psychologist contemporaries viewed grief as a psychological process. For Gorer, grief involved three stages: the initial stage of shock, followed by a period of intense mourning and withdrawal from the world, leading to a re-establishing of 'homeostasis'. Gorer also highlighted different 'styles of mourning'

such as a 'denial' of mourning, 'hiding grief', 'mummification', and 'time-limited mourning'. For Gorer, religious and traditional rituals provided a time frame and activities to the mourning period, the absence of which led to 'unlimited mourning' or melancholia. As with Lindemann, time limits became an important measure of types of grief and Gorer suggested that time-limited mourning was the best means to achieving recovery or homeostasis. Gorer also viewed these styles of mourning as an individual choice, drawing parallels with Lindemann's study where grief work became viewed as an individual action.

Gorer's work, like Lindemann's, has received criticism for its clumsy and generalised analysis (Jalland, 2010). However what is evident from Gorer's study is the focus on individual patterns of mourning and time-limited mourning that resonated in later understandings of bereavement. I suggest that the emphasis on establishing phases and time limits on acceptable and unacceptable grieving served the interests of the psychologist and practitioners working within bereavement care. Having time limits and phases provides a rationale for intervention under the guise of assisting people along the healthy, normal course. Shortly after the publication of Gorer's study the first national bereavement charity Cruse Bereavement Care was established in the UK and the rise of the hospice movement witnessed the creation of the first modern hospice in 1967 at St Christopher's Hospice in South London. Bereavement care was growing into a profession in its own right, with its own designated institutions and organisations along with theories of bereavement, classifications and measures, and therapeutic interventions. Bereavement care practitioners, therefore, had a stake in perpetuating the relevance and demand for their services.

It is not without note, I argue, that the research carried out into grief and

bereavement over the twentieth century to the present day was, and is, overwhelmingly authored by psychologists and psychiatrists, and to a lesser extent, psychoanalysts. The growth of the field of bereavement care and research was situated within what Rose (1985, 1989) has described as the growth of the 'psy' disciplines: psychology, psychoanalysis and psychiatry. For Rose the 'psy' disciplines were established in relation to organisational practices in many European states in the late nineteenth century that sought to organise people en masse in relation to particular objectives such as education, reform and cure. Later, the creation of the National Health Service necessitated the need to manage physical and mental health at the level of the population. The tools developed by psychology aided the institutionalisation of public health by constructing a psychological knowledge of the individual that through statistics and graphs showed 'normal' distribution and identified similarity and difference between individuals. The dominance of the field by a psychologically informed outlook, aimed to build an objective science of grief, shaping the concerns and the type of research that was produced. I return to this point later in Section 2.4 when I review writers who have highlighted the socially constructed nature of grief.

2.2.3 Grief as a process

The following two decades of grief research were marked by the pioneering work of Bowlby (1979, 1980), and further developed in the empirical studies carried out by the psychiatrist Parkes (1972, 2006; Parkes & Weiss, 1983). Bowlby viewed grief as a biological reaction arising from natural selection. Bowlby's starting point was the idea already put forward by Darwin (1872) in his book *The Expression of the Emotions in Man and Animals* in which he sought to demonstrate how humans and animals both

express emotions through similar facial expressions: these included grief. Grief was described as a universal emotion: one that was biologically programmed. Bowlby viewed grief as a separation response, a response that was first experienced in childhood. How people coped with bereavement in adulthood, Bowlby claimed, was largely determined by their experience of separation from their primary caregiver as a child. Bowlby described four phases of grief in adults: 'numbness', 'yearning, searching and anger', 'disorganisation and despair' and 'reorganisation'. Bowlby provided the first successive phase model of grief setting a standard that soon became common practice. This was despite Bowlby's caveats that there should not be any time limits on grief nor were the phases to be considered discrete.

Parkes' work (1972), following from Bowlby, is often considered as providing the beginning of a sound empirical basis for scientifically minded bereavement research (Archer, 1999). A lot of Parkes' initial research focused on the experience of widows, which led to the creation of a phase model that shared much similarity to Bowlby's original model. Parkes described grief as a process rather than a state, a process that involved a 'psychosocial transition'. This referred to the change in identity required in order to adjust to life without the significant other. Parkes also developed the concept of 'assumptive worlds' (1972) to describe how an individual's internal world ruptured in the face of loss. What is present in both Bowlby's and Parkes' work is an understanding of the relational nature of grief. The emphasis on the searching stage of grief, the separation anxiety caused by the other's absence, sought to bring to light a biological reasoning for the experience of grief. For Parkes (2006), grief was the 'cost of commitment'. Earlier in the chapter I described how for Freud attachment to other people and objects was central to the drives of the libido. Bowlby's and Parkes' work provide further explanation for the role of attachment and its cost.

The legacy of Parkes' and Bowlby's research and writing however is that of creating a stage model of grief. The stage model soon became well-established in bereavement research and became a tool for researchers and practitioners alike to identify bereaved people along a linear course and recognise deviations. It therefore provided a basis for psychiatrists and psychologists on which to intervene. The stage model reached its pinnacle in Kübler-Ross' (1970) five stages of dying that were borrowed and applied to the grief process. It was perhaps the succinct nature of the five stages – 'denial', 'anger', 'bargaining', 'depression', and 'acceptance' – which led to their popularity and prevalence not only within the field of bereavement care and research but in the popular imagination (Konisberg, 2011). Davies (2005) noted how the popularity of Kübler-Ross' stages of dying coincided with a shift in palliative care where death was becoming increasingly professionalised and less domestic. From the 1960s onwards, Davies suggested, people were becoming less familiar with first-hand experience of death. The stages were of use in filling this 'experience gap' in people's lives. The beginning of the 1970s also witnessed the beginning of two of the key journals in the field: *Omega: The journal of death and dying* and *Death Studies*. The study of death, dying and bereavement was growing in theory and practice with bereavement and the management of grief always high on the research agenda. A recent overview of the history of publication trends in both *Death Studies* and *Omega* showed how research on grief and bereavement, largely quantitative, has overwhelmingly dominated the pages of both journals above other areas such as attitudes to death and dying and end of life research (Wittkowski et al., 2015).

The next major contribution to the field came from Worden (1982). Worden developed a task model of bereavement in response to the stage model. Worden's task model set out four tasks the bereaved person was to accomplish in order to

successfully resolve his or her grief. The four tasks were: accepting the reality of a bereavement; experiencing the pain of grief or emotionally accepting the reality of the loss; adjusting to a new environment; withdrawing emotional energy from the deceased person and investing in new relationships. Worden (1991) later changed the last task to be concerned with relocating the dead person within one's life and finding ways to memorialise the person, pre-empting perhaps a move away from a model of detaching to one of 'continuing' bonds. The task model Worden described did not have to be completed in a set order and it allowed the bereaved person to become an active participant in their grief, whereas the phases implied passivity. However, the tasks also shifted responsibility for one's grief work to the individual. Further it provided bereavement practitioners with a set number of things to be accomplished before someone could be deemed 'recovered'. Worden's model shaped grief as something to be achieved and overcome individually yet accompanied by counsellors or other practitioners who could guide the individual to resolution. This emphasis on individual agency and responsibility for one's health and well-being, demonstrated through tasks and activities, are early symptoms of recent government policy on happiness, well-being and recovery (discussed in Chapter 5).

Bowlby, Parkes and Worden's phases, stages and tasks remain influential in contemporary bereavement research and practice. All three figures and the results of their work emerged repeatedly in my interviews with bereavement counsellors, presented in Chapter 6, which it could be claimed is proof of their accuracy in describing grief. Alternatively it could simply highlight how well suited such a phase or task-orientated model is to the counselling profession that requires both an assumed normal course from which to identify pathology and justify therapeutic intervention, and also a time-limited model of grief to suit the demands of the

counselling endeavour.

In the next section I discuss some theories and ideas that emerged as a critique of the stage models. However, the early and mid-twentieth century had already laid down some solid foundations in bereavement research that had configured grief as a concern for the 'psy' disciplines. This was achieved by identifying a normal course of grief initiated by Freud and elaborated by Lindemann that allowed for the demarcation of abnormal forms of grief. Detecting and classifying abnormal forms of grief provided psychologists and psychiatrists with a basis for therapeutic interventions, the shape of which was defined by the clarification of the grief process into phases, stages and tasks. In the next section I describe how this established 'risk factors' for certain types of bereavement as well as the formation of certain types of grief as a psychiatric disorder. Within the creation of multiple models of grief, recovery emerged as something prescribed whether through tasks or monitored on a linear process of phases, and as something to be achieved within a given time period. All the while though grief was assumed as a universal phenomenon, a natural response to death. Yet at the same time grief required work whether from the bereaved individual alone or accompanied by a counsellor or expert. This paradox sits uneasily through the psychological accounts described above as well as in the research that followed it, which I now go on to outline.

2.3 A 'new dawn' of bereavement research?

Towards the end of the twentieth century researchers and practitioners influenced by sociological and anthropological studies of grief and bereavement began to question

the orthodoxy of the stage model of grief. The stage theories of grief were criticised for being too rigid and not capturing the complexity and diversity of the grief experience. What followed was a 'new dawn' of bereavement research (Hall, 2014; Rothaupt & Becker, 2007) that proposed non-linear models of grief, and where psychologists sought to emphasise how people construct meaning from loss and how people continue rather than relinquish bonds with the deceased. This 'revolutionary phase' (Walter, 1999) emerged in light of several critiques of the stage models that put the notion of a 'normal' process of grief into question.

Rosenblatt et al. (1976) in their book *Grief and Mourning in Cross-Cultural Perspective* sought to demonstrate how grief was dealt with in different cultures. Their efforts went some way to destabilising the idea that grief had a universal process of recovery, however, they still assumed that grief itself was a universal emotion, which consisted of a set number of symptoms. Wortman and Silver (1989) went further to undermine the assumptions that had already become ingrained in bereavement research and practice, by outlining some of the 'myths' about grief such as the assumption that every person bereaved will feel distress or that the absence of reactions is pathological. They also criticised the idea of 'grief work', as did Stroebe and Stroebe (1991) who argued that the need to do grief work was a 'truism' rather than empirically founded. Stroebe and Stroebe discovered in a study of 60 widows and widowers that avoiding the loss can actually be more beneficial for long-term outcomes. Furthermore, Rodgers and Cowles (1991) highlighted that the growing lack of consensus concerning the parameters of 'normal' grief, seriously jeopardised any attempts to discuss aberrations from the expected response (p. 455).

Later, in 1999 Stroebe and Schut set out their 'dual process model of coping with

bereavement' (Stroebe & Schut, 1999) that intended to critique the 'grief work hypothesis' that formed part of the stage theories of grief. The dual-process model suggested that people oscillate in their grief from a 'restoration-orientation' to 'loss-orientated' activities. A loss orientation would be characterised with facing the loss and focusing on emotions. The restoration orientation would be where the person would focus on new activities, distractions from their grief and building new roles and identity. The aim of the model was to counteract the idea that grief had to move on progressively, and Stroebe and Schut argued that people experienced grief as an oscillation between two different modes. Further, the dual process model aimed to highlight how people continued bonds with the deceased person, an idea proposed by another highly influential new theory of grief: the continuing bonds thesis.

2.3.1 Continuing bonds

Klass et al. (1996) in their edited collection, *Continuing Bonds: New Understandings of Grief*, argued that psychological theories of grief had thus far emphasised the importance of detaching from the deceased as the means to successful recovery. In the introduction to the book Silverman and Klass (1996) instead proposed 'that it is normative for mourners to maintain a presence and connection with the deceased, and that this presence is not static' (p. 17). Their argument was in direct reference to the work of Freud, Bowlby and Parkes, which they viewed as stating that severing ties was the only way to resolve grief. These models, Klass et al. (1996) claimed, were based on a view of the self and the world that saw people as separate from each other. They promoted a modern western world view that prized autonomy and independence and judged dependence as 'bad' (p. 14). Silverman and Klass called for recovery to be replaced with 'accommodation', a term that captured how people

incorporated past relationships into their ongoing lives.

The idea of continuing bonds certainly had an impact on how grief was theorised, yet I suggest that Klass et al.'s argument was not as revolutionary as they made it appear. Throughout the work of Freud, and also that of Bowlby and Parkes, are attempts to articulate the problem that loss poses to human attachments. Grief emerges precisely because it is believed that human attachment is a vital, if not a biological, imperative. So while the stage theories of grief came to be interpreted in a way that emphasised 'separateness', the models were based around the belief that humans were already inherently dependent on others. Furthermore, the continuing bonds theory itself does not overcome this problem, as Árnason (2012) has remarked, to continue bonds still assumes a prior separation. The starting point of the continuing bonds theory is the grieving person who experiences the presence of the deceased, which suggests that what gets continued is a matter of choice by the bereaved person. The very question of what precisely is continued and what is relinquished remains a matter of debate (Field & Filanosky, 2009; Stroebe & Schut, 2005). After all, continued bonds in the form of being haunted by the deceased might be quite unpleasant and somewhat problematic in finding the means to safely accommodate the deceased into one's life. Continuing bonds thus became about how the living can make choices about what ways they might incorporate the dead, whether through keeping photographs on display in home or carrying out rituals that celebrate and honour the dead. The continuing bonds theory, then, was not necessarily one that had the notion of human interdependence at its centre, as it shaped presence only as an inner relationship with the deceased, one that the individual has a level of control over. In this way the work of Klass et al. served to affirm the western values of autonomous agency and individual choice they originally sought to critique.

2.3.2 Meaning-making and stories

Finding a way to continue a relationship with the deceased person might be one way to make the experience of grief meaningful. Neimeyer (2005; Neimeyer et al., 2006; Neimeyer et al., 2010) has claimed that finding meaning from loss is the principal task in coping with grief. Neimeyer based his work on the idea that humans are by nature meaning-making beings that need to make sense of their world and build a coherent narrative. Neimeyer argued bereavement is an instance that challenges established beliefs about the world and people struggle to assimilate the loss into their existing self-narratives. Successful recovery from loss is achieved by reconstructing new narratives through techniques of 'narrative retelling' and 'therapeutic writing' that Neimeyer (2005) recommends. Meaning reconstruction is about 'benefit finding', so that loss can actually serve to strengthen meaning. The failure to reconstruct meaning is associated with chronic and complicated forms of grief. This method thus lends itself well to therapeutic intervention as counsellors can aid the bereaved in reconstructing meaning through retelling the story of the death and finding new narratives. What remains unclear in Neimeyer's work is what types of meaning are to be constructed. Meaning is assumed as a neutral good, but of course having a purpose in life can be directed to many different things, not all that might fulfil the criteria of beneficial. Meaning is also posited as a thing to be found rather than, as the event of a meaningless death suggests, one constructed story of events, a story that is unstable and always in flux. At the heart of the meaning-making endeavour then, is the belief in universal meanings and values, where narratives are tools to find the 'truth'.

Walter (1996), in the first volume of the interdisciplinary journal of death, dying and bereavement *Mortality*, claimed to have found a 'new model of grief' that went against

the 'clinical lore' of past bereavement research. Walter's model shared many parallels with new approaches to grief in psychology and the emphasis on continuing bonds and constructing meaning, in that he described how the work of grief should be about constructing a 'durable biography' of the deceased. The aim was to create a true and accurate picture of the deceased in order to integrate the deceased into one's life. This was in contrast to dealing with or expressing emotions. For Walter healing was achieved not through emotion work but through talking about the deceased with others. Walter's model received criticism from others (Footman, 1998; McLaren, 1998; Stroebe, 1997) who questioned whether Walter's model contributed anything new. Walter's critics argued that the ideas of talking about the deceased in order to integrate their memory was already part of common counselling practice.

Furthermore Walter's model, in striving to build an 'accurate' picture of the deceased, suffered the same shortcomings as the meaning-making approach in that both relied upon the idea that talking about the deceased can construct a 'true' biography or retelling of the deceased. Árnason (2000) pointed out that what is being constructed is not a biography but stories about the deceased, and that these stories are a creative achievement rather than reflecting reality. The stories people tell about the deceased are as much about the bereaved storyteller as they are the person who died. People use devices such as emplotment and build characters to convey their stories. Within stories then, different truths about grief are to be found and these are constantly changing in each retelling. As Valentine (2008) also demonstrated, narratives are socially constructed; people draw on cultural scripts to express their meanings. Narratives and stories thus reveal a complex interplay between the private experience of grief and cultural discourses about grief. Telling one's story is a strategy to preserve the personhood of the dead but it is also a mode of reaffirming the

personhood of the living. Walter drew on the work of sociologist Giddens (1991) who argued that late modern western society has witnessed the rise of individualism where individual identity has become a reflexive project no longer tied to traditions of the past, but freed to be shaped by individual choice and agency. The imperative to individually story one's experience of grief, as well to memorialise individuals, I will argue in Chapter 5, is part of this reflexive project of the self, where identity becomes something to be constantly worked upon, and preserving individual legacy becomes paramount.

2.3.3 A medical model of grief?

While the focus on continuing bonds and narrating meaning remains strong in current bereavement counselling practice (see Chapter 6), research interests appear to remain true to the psychologists' originating desire to establish a scientifically measurable definition of the normal and abnormal course of grief. As mentioned in Chapter 1, research seeking to define the categories of 'complicated grief' and 'prolonged grief disorder' have dominated psychiatric and psychological research into grief and bereavement over the past two decades (Horowitz et al., 1997; Prigerson et al., 1996; Shear et al., 2011; Zisook & Shear, 2009). In an edited volume dedicated to complicated grief, Stroebe et al. (2013) remarked that: 'In our view complicated grief is perhaps the most important contemporary topic of concern both for the scientific community of bereavement researchers and for health care professionals supporting bereaved people' (p. 3). While the draft of the 11th edition of the International Classification of Diseases (ICD-11) includes the category 'prolonged grief disorder' (PGD) and the DSM-5 featured 'persistent complex bereavement disorder' (PCBD) for further research, abnormal forms of grief are becoming not only

theories but also recognisable psychiatric diagnoses to be implemented in practice.

In the studies, successful mourning is described in much the same terms: to be re-engaged in daily life, reconnected to others, to experience hope for a future, for grief to be transformed and integrated. Equally, symptoms of complicated grief mirror those of 'normal grief' such as: intense yearning, intrusive and preoccupying thoughts, loss of meaning in life, incessant questioning and ruminating, caught up in counterfactual thinking rather than reflecting on the reality of death. Yet the emphasis is on the length of time the 'symptoms' are shown and the 'level of impairment' to social functioning (Stroebe et al., 2013).

It could be argued that the ambitions Lindemann first set out in his study in 1944 have now reached fulfilment. Previous research that sought to uncover the normal process of grief has enabled the discovery of complicated or prolonged grief. By continuing in the assumption of the existence of a normal course of grief, the identification of abnormal forms was made possible. Furthermore the normal course of grief is described as an instinctive psychological mechanism that humans possess in order to heal after loss (Shear, 2012). Complicated grief emerges specifically when there is difficulty in progressing through the natural healing process (Zisook & Shear, 2009). The normal course of grief is time-bound to six months, persisting in grief longer is an instance of grief becoming 'derailed'. Intervention is thus warranted as a means to get people 'back on track'. After all, states Shear (2012) it would be 'inhumane to leave such anguish untreated'. Shear further describes how bereavement is analogous to an injury where grief is the 'inflammatory response' and complicated grief the 'superimposed infection'.

There continues to be debate over what complicated grief involves as well as competing definitions by two different groups of researchers. One might expect that if normal grief were instinctive and measurable, complicated grief would, too, be self-evident. Yet whatever constitutes 'normal grief' remains just as contested. However, even those that seek to critique the empirical validity of the diagnostic category of complicated grief (Wakefield, 2013; Walter, 2006) agree that it does exist. In addition, bereavement has now become a focus of neuroscientific research which claims that complicated grief patterns can be identified in the brain (Gündel et al., 2003; O'Connor, 2005, 2012). A study by O'Connor et al. (2008) asserted that in people with complicated grief the part of the brain associated with rewards was activated when viewing a picture of their dead loved one, leading researchers to argue that complicated grief is prolonged partly because people find pleasure in reveries over the deceased.

Biological explanations for successful recovery from grief are present too in the growing research interest in resilience. Bonnano and colleagues (Bonanno, 2009; Bonanno & Keltner, 1997; Bonnano et al., 2005;) have argued that the majority of people who experience grief have a brief period of distress and then return to functioning at the same level as before. This, claims Bonnano, is due to the fact that most people are naturally resilient to difficult conditions including bereavement. Bonnano's claims have disputed the idea that people go through stages and phases. Bonnano and Keltner (1997) also questioned the need to carry out grief work by suggesting that avoiding emotions in grief leads to better adjustment, demonstrated by a study that analysed facial expressions. Those that showed negative emotions lead to poor outcomes later whereas those that displayed positive emotions resulted in better adjustment.

Interestingly while talk of recovery has lost favour in bereavement research, resilience is growing in popularity (Sandler et al., 2008). Balk (2008) described his confusion over this, as resilience implies an even speedier return to normal than recovery. Further, Balk questioned where the element of personal growth was in resilience. However, Balk viewed grief and recovery as a moral endeavour, whereas the discourse of resilience is seeking a scientific reasoning for how people respond differently to bereavement. To claim people are naturally resilient makes sense when grief is a natural and instinctual process. Yet if this were so, then there would be little requirement for bereavement counselling and models of grief. Hence complicated forms of grief provide pathology for the 'psy' disciplines to focus on and provide interventions for. As I argue in Chapter 5, the prominence of research on resilience might be less about instinctual reactions and more about a social context that commends the type of traits resilience involves. In either case increasing reference is made to the brain and biology to provide the explanation for why people succeed or fail in their recovery from grief. This is quite a different notion to thinking about constructing stories and narratives and finding meaning. What remains from this 'new dawn' of bereavement research is a combination of both a broadening in perspective in how grief is conceptualised and a moving away from the grief process, yet an increasing medicalisation of grief that relies upon the presumed normal course of grief that many others have rejected. Subsequently, there has been a polarisation of certain forms of grief as abnormal, justifying the need for psychiatric intervention.

2.4 *The social construction of grief*

In this section I turn away from psychology and psychiatry to explore ideas that have

questioned the belief that grief is a natural process by emphasising the ways in which grief is shaped and policed by different societal influences. As outlined in the previous sections, the psychological canon of grief research made it appear as though Freud was the culprit for promoting a particular definition of grief, yet research from the historical, sociological and anthropological disciplines presents a different picture.

Historical perspectives on grief and grieving culture have illuminated how grief might be considered as at least to some extent culturally constructed. Stearns and Knapp (1996) present how a rich Victorian grief culture was in various ways unseated by modernity. Stearns and Knapp, and the historical work of Jalland (2010), have demonstrated that the changing attitudes towards grief and the management of grief over the nineteenth to twentieth century were not quite the simple narrative proposed in some work (see Walter, 1999). Rather the shift in emotional culture emerged as a reaction against Victorian sentimental grief practices which Stearns and Knapp illustrated through an 'anti-grief' campaign that featured in middle-class popular commentary in newspapers and magazines. The shift was also framed by Enlightenment ideals that regarded excessive grief as unnecessary, as well as religious beliefs in the survival of the soul, which outpourings of grief appeared to contradict. This increasingly modernist and pragmatic outlook on emotions was reinforced by the ubiquity of death that occurred during the First World War that called for people to maintain self-control over their grief.

Yet as Stearns, Knapp and Jalland all emphasise, how grief was experienced did not change, however, the changes in societal norms did foster a disjuncture between the private experience of grief and the changing social prescriptions. In this view there still remained some belief in the reality of the experience of grief apart from its social

norms. Indeed, work that explored the social construction of grief tends to either retain the assumption that grief is natural while granting its cultural differentiation (Klass et al., 1996; Rosenblatt et al., 1976) or alternatively view grief as something that is produced by cultural norms to the extent that it is not possible to speak of any natural 'real' (Árnason, 2001, 2007; Árnason & Hafsteinsson, 2003; Foote & Frank, 1999). A Durkheimian perspective takes the latter view to the extreme, as for Durkheim all emotions were socially produced: 'Mourning is not the spontaneous expression of individual emotions (...) it is a duty imposed by the group' (Durkheim, 1915, p. 397). Durkheim's work on suicide was highly significant for presenting how society produces behaviours, by arguing that a state of 'anomie' is caused by alienation from society not a dysfunctional pathology in the individual psyche. Yet because for Durkheim human behaviours were socially produced and to be understood by reference to the social group of which people belong, the biological individuality of human beings was downplayed, overlooking why people require interdependence in the first place that leads to a state of anomie.

However, sociological perspectives on grief have tended to rest their analysis on the belief that grief is a universal human emotion. Jakoby's (2012) notable proposal for understanding grief as a social emotion highlighted how grief is framed by cultural rules and affected by social structures, yet her theory still depended on the belief that grief is an 'elementary human experience' and integral to human life. Jakoby's contention lay more with the argument that grief involves a higher order of cognitive processes than simply a reaction to biological separation. Grief is a social emotion because it 'emerges from relationships, attachments, expectations, and obligations' (Jakoby, 2012, p. 680). The work of Klass and Rosenblatt (Klass, 2014; Rosenblatt, 2008b) has provided many rich examples of the way in which different cultures

manage grief in diverse ways. In their research the focus is on the diversity of the grief responses and rituals but there is no question that the feeling and emotion of grief is the same. Interestingly, Rosenblatt's perspective on grief shifted in his later works. In his remarks here it is possible to see how Rosenblatt was beginning to see how whatever individual grief was, it could not be separated from the cultural context: 'Culture is such a crucial part of the context of bereavement that it is often impossible to separate an individual's grief from culturally required mourning' (Rosenblatt, 1993, p. 104). More recently in an interview in *Bereavement Care*, Rosenblatt (Rosenblatt & Bowman, 2013) spoke openly about how when he first began publishing work on grief he thought he knew what grief was. However, now he critiques research that assumes grief as an identifiable 'thing'. Grief is not a discrete object, he argues, but a 'sociolinguistic construction'. In Rosenblatt's view, much contemporary work features a great deal of assertiveness and definiteness about what grief is that implies there is an underlying commonality across grieving.

2.4.1 The policing of grief

Rosenblatt's change of perspective highlights how grief is often taken as self-evident even in work that seeks to emphasise the cultural and social influences on grief. Sociological perspectives on grief have striven to relocate grief in a social context by focusing on the social norms around types of death, the 'hierarchy' of grief and how grief responses are managed (Charmaz & Milligan, 2006; Lofland, 1985; Robson & Walter, 2013; Walter, 2007, 2010). Lofland's (1985) article, for example, questioned the universality of grief by emphasising the social shaping of grief, yet as important as her argument is, grief was still positioned as a 'thing' upon which social structures or cultural norms have a lesser or greater level of influence. Because of this, studies that

looked at the social construction of grief tended to view the social as an additional factor that explains variability in how grief is done, but not of what grief is.

This work is certainly not without its value, often emerging in response to the dominant 'clinical lore' of the psychological definition of grief (Walter, 1999). Walter (1999) described the ways in which grieving was policed in modern and postmodern Western society, adopting a broadly Durkheimian view that emotions, namely grief, are disruptive to modern rational industrial society and so require policing or managing. The 'anomie' that can result from feeling alienated from one's social group is underlined in modern societies where there is an absence or decline in traditional mourning rituals to help the grieving person through grief. Instead postmodern society encourages a mode of self-policing one's grief as part of the individual reflexive project of self, as mentioned in Section 2.3.2, of which the maintenance of a coherent self-narrative is part.

There is a large body of work that has described a condition of 'disenfranchised grief' that is seen to occur when someone's grief is not socially acceptable or recognised (Doka, 1989). Proponents of disenfranchised grief theory proposed that all grief should be considered in equal terms and that restrictive social norms around grief should be eradicated. As Fowlkes (1990) described, different types of losses are assigned differential social merit. Some losses are conferred a socially legitimate right to grieve while others are not. For Fowlkes these normative criteria have implications for how people experience grief and role they are assigned, thus forming a hierarchy of grief. Walter and Robson (2013) argued against the very concept of disenfranchised grief itself by stating that a person can undergo a 'process of disenfranchisement' but grief itself cannot be 'disenfranchised.' Walter and Robson

(2013) instead argued that norms are essential to grieving and that all losses are not equal and thus hierarchies of grief are required to determine appropriate responses to grief.

It seems that at the centre of discussions of disenfranchised grief is the need for social recognition and the consequences of failing to be recognised. This suggests that dealing with grief is an interdependent and socially informed activity. A hierarchy of types of loss expects different modes of behaviour and emotional expression appropriate to each loss. The hierarchy is thus constructed and maintained through an understanding of what lives are considered 'grievable'. To be considered grievable one has to have been recognised as living a life worth living while they were alive (Butler, 2004). As Walter and Robson comment, to grieve too little or too much might require careful presentation of the self to appear to be grieving appropriately and thus elicit the appropriate responses from those around them. The grieving individual therefore might be recognised via the hierarchy yet might also still feel a sense of disenfranchisement due to the gap in felt emotion and the emotions they present to others.

2.4.2 The disciplining of grief

I now go on to discuss work that sought to question the 'truth claims' of the psychological and psychiatric theories of grief. Curiously, psychologists tend to be blind to the effects of their own theories on the concept of grief, so much so that when they seek to outline the social and cultural nature of grief and how cultural contexts 'oppress' or 'police' expressions of grief they neglect to identify how counselling or therapeutic interventions contribute new regulatory norms and perpetuate existing

ones (Harris, 2010; Neimeyer et al., 2014). It is apparent in this lack of reflexivity that psychologically informed theories of grief are understood not in the same terms as cultural discourses about grief but as revealing a fundamental 'truth' about grief.

Wambach's study (1985) presented well what happens when the construct that was supposed to reflect reality becomes more real than the actual reality that it purported to demonstrate. In her study of widow support groups she found that the grief process, composed of stages, was taken as a factual account of the experience of grief. When Wambach herself sought to challenge the order of the process she was dismissed by the women who retorted: "You can tell you've never been through it" (p. 204). Often the women's experience would contradict the stages, which caused distress and yet the process was so naturalised most widows did not realise the grief process had an origin and was a social creation. Instead the process was a means to monitor themselves against a timetable and to judge their progress.

Foote and Frank (1999) adopted a Foucauldian approach in their analysis of bereavement counselling and theory. They argued that grief was a 'site of disciplinary power' upon which claims about the truth of grief were made. These claims, they argued, were productive in Foucault's sense of the word, in that certain claims on the truth of grief, such as the grief process, create bereaved people as 'docile' subjects. This was demonstrated in Wambach's (1985) study where the women began to monitor their own progress against a timetable they assumed was true. For Foote and Frank the bereaved become objects of knowledge to be known by therapy and shaped by therapeutic knowledge. This, they claim, reiterating sentiments expressed earlier in this chapter, was possible because of an assumption of normal grief upon which the clinical criteria of abnormality could be established, criteria that continue to

expand until the normal is defined out of existence. The normal thus remains less a reality than a therapeutic ideal. Yet the normal is required to support the technology that relies upon it. As discussed in this chapter, therapeutic intervention in bereavement has been based on the premise that there are normal and abnormal responses to death and loss. This division, argue Foote and Frank, must exist in order to demarcate the abnormal as the legitimate object of therapeutic intervention: 'Abnormal is what can be brought back to normal by means of therapeutic fixing' (p. 164). Further, Foote and Frank suggest complicated grief could be interpreted as an 'embodied refusal' to adhere to the norms of bereavement.

Árnason's work (1998, 2001, 2007; Árnason & Hafsteinsson, 2003) also employed a Foucauldian perspective in his ethnographic research of bereavement counselling organisation Cruse Bereavement Care carried out in the late 1990s. Árnason explored how bereavement counselling produced certain ideas and 'truths' about grief and served to produce bereaved clients as individual autonomous beings 'encouraged to govern themselves, as befits a liberal and democratic regime' (2007, p. 49). What Árnason demonstrated in his work was the notion of personhood implicated in bereavement counsellors' understanding of grief and emotions. It is a paradoxical personhood that is both individual and autonomous yet liable to devastation at the death of another. Árnason's study linked together the management of grief in Cruse and the theories it used with the discourse of neo-liberal governmentality. Bereavement counselling was viewed as a technology through which individuals learned to govern themselves and their emotions in accordance with political processes of subjectification. Contrary to theories and practices of grief that assumed an idea of personhood as individual and autonomous with a need to express emotions, Árnason argued this was an idea of the self that was produced through

techniques such as bereavement counselling. In response to Walter's claim of the postmodern 'revival of death' that emphasised choice, individuality and a liberation from previous restrictive norms, Árnason and Hafsteinsson (2003) highlighted how, to describe the postmodern revival of death as the efforts of ordinary people to express their emotions freely, 'is not only to naturalise the need for emotional expression but misses sight of the effects of neo-liberal governmentality' (p. 59). Bereavement counselling was a device for meaning production, one that naturalised the notion of the self and its emotional expression, as individuals with an 'inner' emotional life. This links to an earlier point raised in Section 2.3.2 referring to the rising interest in narrating stories as a means to recovery. The belief that stories can liberate someone from trauma depends upon the assumption of this particular notion of personhood that needs to tell one's story and will find autonomy and freedom in doing so, an idea I return to in Chapter 5.

In this section I have attempted to show the ways in which the psychological notions of grief have been criticised and relocated to a social context to highlight how grief is shaped, regulated and policed. Throughout much of this work however, grief is still positioned as 'a thing' upon which the social has its influence to varying degrees. Grief is universal but its recovery is context dependent. Complicated grief is then a consequence of a missing, inadequate or twisted larger cultural response (Klass, 2014). However, as elucidated by Árnason, the ethos of bereavement counselling produces a certain type of personhood, a personhood that coincides with a neo-liberal governmentality. The way in which identities are produced through bereavement counselling will be analysed in depth in Chapter 6.

2.5 Summary of the literature

In this chapter I have traced the growth of research into grief and bereavement, attempting to unpack how grief has been theorised and the implications this has had for notions of recovery. Throughout there has been an assumption of a certain type of person who has a natural, instinctive capacity to grieve. Árnason's work mentioned above has critiqued this type of personhood by exploring how an autonomous, individual subjectivity is produced and naturalised through bereavement counselling. Throughout the psychological theories of grief was an absence of critical reflection on both what type of person is being assumed in the models and further what type of person might be produced through therapeutic interventions. What emerged was a paradoxical figure, first highlighted in Freud, who seeks attachment as a means of survival but, in the event of losing the loved object, must regain autonomy in order to recover successfully. This is an autonomy that appears to prefigure the bereavement and yet to feel grief it would imply that one must have already relinquished one's autonomy by entering into relationality.

It would seem from much of the work reviewed in this chapter that this paradox is a biological one. Yet from an evolutionary perspective grief poses a puzzle. Grief can be construed as a by-product of natural selection, which, as Bowlby sought to demonstrate, was an important reaction to separation. Anxiety and distress at the separation of a primary caregiver was an adaptive response, as their absence poses a threat to survival. However, it is clear that grief is not considered to have any adaptive function. Rather grief is widely viewed as maladaptive, hence the wealth of studies outlined in this chapter that have sought to remedy its negative effects on the

morbidity of the population. The puzzle grief poses thus might explain why many have viewed grief as a disease or pathology (Engel, 1961). Archer (1999) concluded that grief is a 'trade-off', and like Parkes viewed grief as the cost incurred 'in pursuit of something which has an important adaptive consequence' (p. 250).

Grief is a response, suggests Archer, 'an alarm reaction set off by a deficit signal in the behavioural system underlying attachment' (p. 153). This alarm reaction, involves a link between evolutionary principles and a behavioural mechanism that is characterised by the strength of the attachment. As Darwin claimed, it is not only humans who show signs of grieving. Other studies have sought to explain that animals grieve in similar ways to humans (King, 2013). This appears to suggest that there is a common evolutionary response to absence. However, it is also clear that the forms grief and its recovery takes are strongly culturally determined. It is pertinent to ask then, how and why 'prolonged' or maladaptive forms of grief occur. For, if grief is a natural response, why does grief require 'work' and why does its recovery take 'unnatural' forms?

In the next chapter I seek to remedy this paradox by drawing upon work that has problematised the notion of the autonomous individual by emphasising the embodied and relational nature of human beings, to suggest that people are always already not the autonomous person they (or others) might take themselves to be. This leads me to detail how I am theorising grief in this thesis and to pose the question: when the bounded autonomous individual is not taken for granted, what might a theory of grief look like?

CHAPTER 3

Towards an alternative way of theorising grief: Emotions, bodies and practices

3.1 *Introduction to the chapter*

In Chapter 2 I reviewed the theories of grief that have dominated the field of grief and bereavement research over the last century, since Freud first proposed his theory of mourning and melancholia. In reviewing the ways in which grief has been conceptualised I highlighted some key assumptions in the literature. In this chapter I challenge these assumptions by highlighting the role of emotions, bodies and practices, often overlooked in a predominantly psychological and psychodynamic view of grief. By drawing on this alternative literature I seek to challenge the disembodied view of the bereaved person that appears in dominant grief theories and bring into the view the embodied, relational and liminal experience of grief. In this respect I also challenge the Cartesian (Descartes, 1649) divide between the understanding of mind and body that I argue persists in theories of grief and the study of emotions more broadly.

I begin this chapter by explaining the concept of liminality and describe how I have used liminality as a conceptual basis on which to problematise the boundaries around emotions, bodies and practices. Drawing on the work of van Gennep (1960) and Turner (1969, 1982), I argue that following bereavement people may find themselves in a space of liminality where their sense of identity is destabilised, and the usual

order of everyday life has been suspended. I suggest that bereaved people are liminal bodies, 'matter out of place', due to the threat they pose to the dominant understandings of the emotions and the body.

In the following sub-sections I focus on emotions, bodies and practices in turn to explore further how an emphasis on liminality can provide an alternative perspective to theorising grief. First I refer to the large field of research into understanding and categorising emotions. Rather than emotions being discrete and easily measurable, I present how the interdisciplinary study of the emotions has yet to find a conclusive answer to the question: 'What is an emotion?'. Further, I describe the recent 'affective turn' where emotions are being rethought as non-conscious bodily processes, as a way to reconsider grief as an embodied and relational experience. This leads me to the second section where I focus on the 'lost' body (Tanner, 2006) in grief theories, and highlight literature that has emphasised the embodied experience of grief. Within this I return to Freud's theory of mourning and melancholia through the work of Butler (2003, 2004, 2010) to consider grief as an instance that reveals a radically relational model of self, foregrounding vulnerability and precarity as fundamental to the human condition. In emphasising the relational aspect of bodies, I argue that in a society that favours individual autonomy and recovery, bereaved people become seen as problematic bodies to be managed.

I then bring together the discussions on the body and emotions by borrowing Wetherell's (2012) concept of 'affective practices'. I suggest that an analysis of practice can allow for an account of grief that views grief as both a bodily felt, affective experience *and* something that is managed and maintained through social practices. Emphasising the role of practices and social activity, I seek to build towards

an alternative way of theorising grief where grief is not something that exists purely in the psyche but is a socially constructed object, framed and produced by various discourses, including the psychological ideas outlined in the previous chapter. In the final section I piece together the vision of the person that is implied in the claim that grief is both an embodied, felt experience that reveals the fundamentally relational nature of human beings, and yet also a socially constructed category that refers to a range of emotional behaviours, none of which can be defined conclusively as 'natural'.

3.2 *Grief and liminality*

In this section I suggest that the experience of grief is one of entering into a space of liminality. The word liminality derives from the Latin 'limen' meaning threshold or margin. Turner (1974, 1982) described a stage of liminality as one where the usual order of things is suspended, the past is momentarily negated and the future has yet to begin. By comparing grief with liminality, I argue that following bereavement people may experience their sense of identity, and their sense of reality, has been suspended. Turner (1969) described those in a liminal stage as 'threshold people' who elude the classifications that normally locate people in space. In the liminal period the characteristics of the subject become ambiguous. As Turner states: 'Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial' (p. 95). In a state of liminality people exist outside not only their own social position, but all social positions. Being 'betwixt and between' causes one to literally and figuratively lose one's sense of being in the world.

By focusing on liminality I seek to highlight how grief can be an experience that destabilises familiar boundaries around identity, social norms and behaviour. A state of liminality can provide opportunity for creativity and subversive acts due to the eradication of the normal structures that tend to inhibit or obstruct behaviour (Turner, 1974). As Turner (1982, p. 47) described: 'Liminality is both more creative and more destructive than the structural norm'. However, in such a state people might be prone to suggestibility, social influence, imitation, and contagion, for under liminal conditions there is no structure to objectively measure against. Stenner and Moreno (2013) suggest that when the taken for granted is swept away, people can easily lose 'grasp of external reality' and their 'sense of inner self-coherence'. The ambiguity of liminality from which stems its potential may also be the scene of disease, despair, death, or suicide: of a breakdown without replacement of well-defined social ties and bonds (Turner, 1982).

In conceptualising grief as an experience of liminality I seek to problematise the idea of a linear process of grief often promoted in grief theories. In his anthropological studies van Gennep (1960) defined liminality as the middle phase of a 'rite of passage' undergone by members of tribal societies: the initial stage of separation from one's group or society, the middle stage of liminality and the final stage of reintegration. By comparing the experience of grief to one of liminality I seek to argue that the liminal phase can become the new permanent reality for bereaved people. Rather than a phase in a staged process, I am arguing for an understanding of grief as something from which people do not always recover. Describing grief as a liminal space then, I am not suggesting grief follows the logic or structure of ritual, but on the contrary is an experience where familiar structures have been destabilised.

Rituals such as funeral rites and traditional burial customs have historically been considered as aids to move people through the mourning process. Van Gennep (1960, p. 147) described mourning as a transitional period that was entered through 'rites of separation' and emerged from by 'rites of reintegration' into society. Van Gennep highlighted the fact that often the duration of the mourning period would correspond exactly with societal ideas about the amount of time it might take for the deceased to become incorporated into the world of the dead. Before this reincorporation, both mourners and the deceased are suspended in a space between the world of the living and the world of the dead. In contemporary western societies, interventions such as bereavement counselling, or popular self-help books that proscribe steps through the process, similarly act as guides through the liminality of grief to what is considered to be an agreed 'good' resolution.

Rosaldo (1993) critiqued the way the anthropology of death and mourning had focused on ritual at the expense of the study of the emotional experience of grief, highlighting the problem of studying grief through the logic and order of mourning rituals. Rosaldo argued that the over-emphasis on ritual meant that the ritual process had been conflated with the process of mourning; rituals were viewed as 'containing' emotions, and conveying social and cultural attitudes towards death. Rosaldo drew on his study of the Ilongot tribe in the Philippines, whose members felt impelled to hunt and chop the head of a person following bereavement. The 'rage' expressed by the Ilongot's, Rosaldo argued was an example of the way the study of mourning rituals had failed to convey the emotions of grief.

However, Rosaldo's critique of the anthropological study of grief still relied upon an understanding of grief as a universal emotional experience that is, for instance,

overwhelming and powerful, which as Arnason pointed out (1998) is a particularly western notion. This is highlighted in the way Rosaldo describes how sharing the experience of bereavement enables him to understand those of a different social and cultural background. In the following sections of this chapter I will address the common assumption that emotions are universal, biological phenomenon and suggest instead that what are understood as overwhelming emotions such as the rage discussed by Rosaldo are also shaped and constructed by the social context.

For Durkheim (1915), as mentioned in Chapter 2 Section 2.4, emotions were central to ritual action. Rituals reinforced social values, fostered identity and built solidarity aided by emotional responses. Ritual practices and emotions are thus intertwined and may play an important role in producing social stability, particularly at moments when people are undergoing periods of liminality. For Bloch and Parry (1982), mortuary practices served to reassert social order at death. Yet they further described how social order is itself a product of rituals: social order does not exist prior to ritual. Ritual thus has a productive role in the liminal space of grief in reasserting current norms of grief and recovery but also the potential to create new ideas about grief. Davies (2011) also emphasised the role of the body in such ritual action in his term 'moral-somatic' processes, which referred to how people respond to social values through embodied action. In this thesis I highlight the different types of rituals bereaved people might engage in, including everyday informal rituals and practices (see Chapter 7 Section 7.3). Ritual and emotion then, rather than separate fields of experience are intricately intertwined, as I demonstrate in Section 3.2.3 by using Wetherell's concept of 'affective practices' to argue that grief cannot be understood apart from the rituals that societies use to manage, express and perform grief.

In this thesis I conceptualise grief as a virtual space of liminality that is experienced within the psyche but also in interaction with other people, organisations and institutions. So while a liminal space provides opportunities and possibilities to inhabit new identities, the space is also filled with various people and ideas to guide people in a particular direction. Becoming reincorporated into structure, as in the final stage of a rite of passage, is a way to control the danger the liminal person poses to the smooth running of society. For example, the time restraints placed on grieving, as demonstrated in the diagnosis of 'prolonged grief disorder' where the display of grieving symptoms at six months following bereavement might signal the need for clinical intervention, could be seen as a way to reintegrate people who have been cast into liminality back into a linear ordered sense of time. In Turner's (1969) description of liminality, these rituals and customs serve to provide staging to the process, not in order to close down options but to facilitate a productive 'becoming'. In using the concept of liminality to describe the experience of grief, I aim to explore how the final stage of reintegration, or 'recovery', is socially and culturally constructed. I argue that what constitutes recovery or reintegration, while achieved or resisted with varying degrees of success, is something that must be continually negotiated and maintained, and this negotiation takes place within the shifting boundaries of the liminal space of grief.

In the following sub-sections I highlight the intertwined nature of emotions, bodies and practices that play an important role in enabling people to find meaning and construct identities in the liminal space of grief. Furthermore, ritual practices, whether a funeral or a bereavement counselling session, seek to manage people across the transitional space of grief, maintaining the boundaries and 'margins' of what is taken to be reality in society. As Douglas (1966, p. 122) has argued, pulling

margins 'this way or that' is a dangerous act that can alter 'the shape of fundamental experience'. By drawing upon liminality I am attempting to illustrate the 'vulnerability' (Douglas, 1966) of taken for granted assumptions about grief that persist in modern western societies. Bereaved people have the potential to challenge these boundaries by existing between the divided worlds of the living and the dead and inhabiting this margin, or space of liminality.

3.2.1 Theorising emotions

In Chapter 2, I argued that even among studies that analysed the socially constructed nature of grieving behaviours, grief was still assumed as an entity located somewhere in internally felt emotions that could be differently shaped and expressed. In a similar way, the study of the emotions has historically rested on the Cartesian divide between body and mind and emotion and reason, where the biological and the social constructionist understanding of emotions have been unhelpfully positioned as separate phenomena that can only be studied in isolation. However, as I discuss in this section, the study of the emotions has long been a focus of a variety of disciplines from the biological and psychological, to the philosophical, sociological, and anthropological and more recently as a focus of neuroscientific research.

Nevertheless, defining emotions has remained a contentious topic across the disciplines. As Dixon (2012) has shown, a glance at the history of the term 'emotion' reveals that what actually constitutes an emotion is not as fixed as it has been purported to be by researchers of emotions. Dixon detailed how 'emotion' did not become a word to describe mental states until the mid-nineteenth century, prior to which the terms 'passions' and 'affections' were more commonplace. The term

emotion gained favour along with the rise of psychology as a discipline that sought to move away from both the religious connotations of 'passions' and the medical usage of 'affections'. Dixon traced how the term emotion originally denoted a physical agitation or disturbance in people and animals alike and later came to be accompanied by mental feelings. Thomas Brown, who first established the term 'emotions' within psychology in 1820, admitted that emotions cannot be defined (Dixon, 2012), and later James' essay published in 1884 entitled 'What is an emotion?' (James, 1884) captured the sentiment, yet concluded without an answer.

It is not surprising that something that could not be defined from the outset continues to resist easy classification. Yet the meaning of terms generally considered to designate emotions - such as anger, fear, sadness, happiness, disgust or surprise - appear obvious not only to researchers who have produced vast fields of studies under such categories but also in everyday discourse where the terms apparently possess a universal understanding. The belief in a set of basic emotions, commonly including the ones listed above, was a development arguably beginning with Darwin's (1872) theory of the emotions as primitive, innate and involuntary instincts. Darwin's description of grief, for example, described the expression of grief in terms of a contraction of the 'grief muscles' that produced a particular facial expression. In Darwin's understanding there was no acknowledgement of the cause of, or the context of, emotions but rather they were something that passed through the body over which the person has no control. The evolutionary view of emotions then, was that these were common to all humans and non-human animals.

The belief in a universal set of emotions was extended in the work of Ekman (1992, 1993) who carried out studies in which people from a range of cultural backgrounds

were asked to identify different emotions from facial expressions, from which Ekman concluded there was a set number of 'basic emotions' common to all humans. Ekman's work was and remains highly influential while the ambiguous origins of the term emotions have been somewhat lost. Instead, emotions have been classified further into varying numbers of primary and secondary ones. Kemper (1987) outlined four primary emotions - happiness, fear, anger and sadness - that qualify as such due to having five features, which are:

- 1) Evolutionary survival value
- 2) Appear in earliest stages of human development
- 3) Universally recognised in the face
- 4) Have unique autonomic responses
- 5) Emerge in all social relations

Secondary emotions were formed from a combination of primary emotions, for example anger and sadness constitute the secondary emotion of grief. For while it is believed that primary emotions are 'hardwired', it is unclear whether secondary emotions are innate or culturally defined. Primary and secondary emotions are also described as 'lower' or 'higher' emotions where, as Descartes (1649) noted, the higher emotions emerged from initial 'lower' emotions. Lower emotions were thus considered as body automatic responses to external stimuli, whereas higher emotions demanded the intellect and involved cognition³. However, many have found fault in Ekman's extensive studies (Barrett, 2006; Mead, 1975), not least with his interpretation of the findings, where the identification of facial expressions to

³ This distinction between bodily instincts and urges and rational intellectual reasoning is found in Freud's description of the two competing forces of the unconscious: the 'id' that refers to human primal urges, and the 'superego' that guides behaviour according to societal norms.

emotions had a variable success rate. It would be presumed that something universal would occur in the vast majority of cases. Ekman's model also relied on facial expressions as being the defining feature of emotions, as though emotions are purely bodily responses rather than viewing facial expressions as communicative and intentional.

The neglect of emotions in sociology began to be addressed by work that emerged from the 1970s onwards that highlighted the culturally diverse appearance of emotions as well as exploring how emotions are socially constructed (Dixon, 2012; Harré & Parrott, 1996). As Turner and Stets (2005) argued, biology had become the 'black box' sociologists refused to enter. Williams (2001) detailed the dualism of emotion and reason evident in the foundational, and overly masculine, works of sociology by Durkheim, Marx and Weber that served to perpetuate the understanding of emotions in sociology as irrational and separate from the rational mind. A challenge to this thinking emerged in different forms: feminist critiques of the rational body, a growth in interest in the role of the body in social theory as well as research into consumer culture and emotional labour (Hochschild, 1983; Lupton, 1997; Shilling, 1993; Turner, 1984). The sociology of emotions thus sought to bring together the social, cultural, and biological to rethink emotions as not only a bodily agitation, but as intentional and involving a moral order (Harré & Parrott, 1996).

Harré (1986) critiqued the psychological study of emotions and what he saw as the psychologist's belief in an abstract 'it' that assumed the existence of emotions as discrete entities and studied them as such. Rather, for Harré, emotions could not be studied without close attention to the local language and 'moral order' in order to understand the differences in the meanings and uses of emotions. Harré proposed a

need to explore emotion 'vocabularies' that would focus analysis on the strategic use of emotion. He also noted the need to acknowledge the social function of emotional displays and the system of rules that maintained and taught emotional expression. However, it is only after focusing on language, discourse, and social rules, Harré claimed, that the physiological details of the various bodily 'perturbations' that accompany the activities can be engaged with and tracked, as the extent to which the perturbations are important and how they are managed will vary according to local culture.

Harré's argument, by separating the analysis of language and the body presents an example of how the Cartesian divide between mind and body is often repeated in the study of emotions. Ahmed (2004) described this thinking as either an 'outside-in' or 'inside-out' perspective. An outside-in perspective would consider emotions as properties of social and cultural practices that 'get inside' the individual whereas an inside-out perspective would see emotions as something innate to the individual that emanate from within out onto the world. For example, Harré above was arguing for an outside-in study of the emotions, where the discourse of an emotion produces bodily perturbations; whereas the psychologists believe emotions are something 'inside' that comes 'out'. Hatfield et al. (1994) in their book on 'emotional contagion' argued that emotions can leak out of one individual and can be 'caught' and 'infect' others. Their argument highlights well the problems with thinking about emotions as something that can come from outside and 'infect', or 'leak' out from inside. In each case emotions are viewed as things that people have or gain, or that they catch and have little control over. Following Ahmed (2004), I argue that rather than stating people come to be infected by or leak out emotions, emotional expression can blur the boundaries between bodies. This way of thinking about emotions therefore

maintains neither an 'outside in' nor an 'inside out' perspective.

The recent interest in the study of 'affect' provides a way of theorising emotions that attempts to overcome this divide between emotions and bodies. The trend towards studies of affect regards emotions as both biological and social phenomenon, capable of inhabiting and moving between bodies. The use of the term affect refers to the human bodily capacity to affect and be affected. From this, two different meanings have emerged in social and cultural analysis: one is to develop the notion of embodiment to appreciate the non-verbal, non-conscious aspects of human bodies. This also includes thinking about emotions as less structured and less socio-linguistically fixed (Ngai, 2005). Second, the affective turn has heralded an ontology that thinks beyond or post human. The capacity to be affected by other bodies but also non-human objects and the environment at large is seen to provide a way of overcoming divides between not only mind and body, but nature and culture as well as self and other. In this way affect theory owes much to feminist work on the body (Haraway, 1991), but is greatly inspired by Deleuze and Guatarri (1984, 1988) and a select group of neuroscientists (Damasio, 1994; Massumi, 2002).

Biology is reconfigured in affect theory so that biological explanations for social behaviour are no longer considered essentialist and reductionist but as a creative space that injects potentiality in understandings of the human body. This is curious considering that the term 'affect' has quite a different legacy in psychology where affect is often used interchangeably to refer to emotions where emotions and affect are innate, largely physiological responses that can be categorised and measured. By contrast, the embrace of biology by certain cultural theorists writing on affect, depict a dynamic, mutable material body that defies all boundaries. Affect theory is

positioned as a response to 'old' structuralist or constructionist social and cultural theory that distanced itself from biology as well as a theorising of the body and emotions that over-valued rationality and reason producing tidy disembodied accounts. The body in affect theory rather is not fixed but fluid, composed of 'lines of flight' (Deleuze & Guattari, 1984) or intensities rather than Freudian drives.

Affects are characterised by their movement and how they are 'transmitted' between bodies. For Brennan (2004), the transmission of affect counteracts western notions of the 'affectively contained' individual by showing how the social and psychological produce physical, bodily changes. Affect seeks to capture the 'puzzle' of suggestibility that therapists and analysts described as the concept 'transference' (Blackman, 2013). As Blackman details, this notion of suggestibility captured in psychoanalytic understandings of the unconscious or psychic realm lost favour but has now returned in a scientific and biologically informed manner. Psychoanalytic understandings of grief in Freud (1917) and Klein (1940) relied upon a belief in the way in which people incorporated others within themselves, described as object-relations or attachment, where the ambivalence experienced at the actual or imagined loss of the object risked destabilising the ego or self. However, affect theory that depends on neuroscientific findings tends to dismiss psychoanalysis as part of the theoretical framework that promoted the bounded and separate human being. Yet arguably the melancholic presents the perfect affective subject, for the melancholic has no conscious knowledge of what has been lost in her or himself; the boundaries between the deceased and the living, self and other, are blurred and fluid.

Many scholars privilege the use of affect over emotions. Fox (2013, 2015), for example, claims that affect can go beyond what he considers the limitations of the

sociology of emotions. Emotions are only a sub-component of a broader 'affective interactivity' between bodies and non-human entities. Viewing emotions in this way overcomes the distinctions between structure and agency, nature and culture to which Fox claims sociology falls prey. Thus Fox borrows from Ahmed (2004) to suggest a mode of studying emotions that looks at not what emotions are but what they do. This shifts attention away from the individual to address 'emergence' rather than 'substance'. Tracking the impersonal flows of affect is Fox's attempt to decentre the human, individual, rational actor as the starting point of enquiry to explore how the individual is but one element in the circulation of affects.

However, a key problem in Fox's argument, which is often repeated in other writings on affect, is that the flow or intensity of affect is given undifferentiated power. So while I would agree that an acknowledgement of the ways in which people are relationally constituted is beneficial for destabilising the notion of the autonomous individual, attention needs to be given to precisely the different ways in which people are affected, as well as how people might not be similarly affected by the same 'flow' of affect (Anderson, 2009). The emphasis is overwhelmingly on how affect flows but not how affect gets stuck, on how some bodies become stuck rather than move in a continual flow (Ahmed, 2004, 2011). Thinking about how some bodies get stuck might allow researchers to consider what makes it possible for a body to become affected and what makes a body resistant. The overemphasis on the 'free' and 'flowing' nature of affect and emotions negates the role of bodies and structure (Stenner & Moreno, 2013).

The affective turn is an interesting move in the study of emotions that has shed some light on the importance of thinking about the affective capacities of bodies. However,

the multi-disciplinary study of the emotions remains conflicted over the question of what emotions actually are. Situating the study of grief within this broader multi-disciplinary field I argue is important in order to challenge the idea that grief is a 'natural' and stable category of the emotions. From this starting point the study of grief takes quite a different perspective. Nonetheless, the varieties of disciplines that have studied the emotions have failed to appreciate the role of the body in experiencing and expressing emotions. In the next section I turn to explore the role of the body in grief and highlight studies that emphasise the embodied and relational aspects of grief to address the disembodied understandings of the emotions discussed so far.

3.2.2 Theorising bodies

While suggestions of the biological underpinnings of grief reactions are present in psychological theories of grief, the body remains markedly absent. Grief is understood as an emotional response that occurs in the individual psyche. Tanner (2006) has argued that within theories of grief the body becomes 'lost' where mourning, as many have argued is to be found in Freud's theory, is described in symbolic, disembodied terms. For Tanner, grief is unavoidably an embodied experience and definitions of mourning that disavow the embodied dynamics of grief reflect a cultural discomfort with the 'rupture of autonomy' manifest in both the fact of embodiment and recognition of intercorporeality (Csordas, 1994, 2008).

The discomfort with intercorporeality in western theories of the body is all the more present when dealing with dead and dying bodies. The body in death is a reminder that human beings are in constant flux and subject to change. As Hallam et al. (1999)

have noted, there has been a under theorising of the body in death studies. Where embodiment has appeared it has tended to imply bounded, alive bodies. They argue that embodiment needs to expand its focus to 'vampires': the 'disembodied dead', to selves not bounded by the body; and to 'vegetables', mortal, permeable and not autonomous bodies. Switching focus to the socially dead/biologically alive and the socially alive/biologically dead, circumvents the Cartesian dualism between body and mind to a human embodiment which situates itself at and beyond the boundaries of the body.

It would seem that some bodies are allowed to be present and others are encouraged to be absent. Bennett and Bennett (2000) found in their study of bereaved people who had experienced the presence of the dead that their participants would move between a materialist domain of thought and a supernaturalist domain to make sense of their experiences. The study revealed how participants in their narration of their experience drew on the sorts of modern rational discourse that classified dead bodies as separate from living ones, as well as the participants' own fears of being considered delusional at seeing and feeling the dead. Within a rationalist logic, experiencing the presence of the dead would be considered illusionary and dismissed. Bennett and Bennett argued for the need to embrace alternative ways of thinking that would allow for such experiences of the presence of the dead to be considered as equally rational and real.

The ways in which certain bodies are made absent also reveals the boundaries placed on bodies to perform and appear in socially normative ways. Hockey et al. (2010) drew on Douglas's (1966) notion of 'matter out of place' to describe how certain bodies, in particular dying and dead bodies, become matter to be managed. Howarth

(2000) argued that a scientific approach to mortality is the product of modernity that relies on the assumption that life and death are clearly separate, developing classificatory systems and from which the models of grief have emanated. Bereaved people appear to embody this divide, posing a problem in a society orientated around life and troubled by death. This division between life and death, claimed Howarth, is not a fact but rather a false boundary borne out by a modern need to segregate and classify. What is needed is not to find yet another model of grief, but to work to blur the boundaries between life and death.

As described in the opening Section 3.2, this 'polluting' of boundaries is managed through ritual, which Douglas (1966, p. 97) described as separating the person from their old status, and segregating them 'for a time' before publicly declaring their entry into a new status. The 'danger' lies in this act of being in transition: of being neither one state nor another. The person who is in transition and indefinable is himself or herself in danger and emanates danger to others. 'Complicated grievers' for example may be considered polluted and in need of classification due to what is considered their proximity to the deceased person. The bereaved person is thus 'betwixt and between' the margins of life and death: they are not wholly living, as their bereavement means they are emotionally distanced from the world as they cling to the memory of the dead, but nor are they wholly dead, for of course they are in fact literally alive.

'Out of place' bodies also gain a level of power due to being on the wrong, or neither, side of the boundary. As Foucault's work (1963, 1973, 1976) has demonstrated, non-normative bodies require forms of discipline that act upon the body through 'bodily regimes'. Power over bodies, or 'biopower', is not total and fixed but mobile and ever

changing just like human biology. Where power is present so also is resistance, or at least the possibility of resistance. Foucault alluded to bodily agency in his concept of 'biopower' where he described 'life' as a force that resists and escapes power and can never be quite fully controlled (Foucault, 2003). Foucault argued it was the materiality of the body, prone to errors and dysfunction, which necessitated the need for power in the first place. Yet what are considered as 'errors' or abnormal are precisely dependent on the historical context.

Foucault received criticism for his failure to explain resistance (McNay, 2009), but I interpret Foucault's description of biopower as one where resistance is not necessarily conscious or intentional but a description of how 'unruly' bodies can challenge boundaries. Resistance is the failure to embody the 'figure of man' I referred to in Chapter 1 that underpinned Foucault's work and which he sought to challenge. People and actions then get read as resistant when they do not fit into the discursive 'régimes of truth', when for instance they blur the boundaries between mind and body. Resistance to power therefore finds its possibility in that 'life' which escapes power, in the materiality of the human body that cannot be quite grasped by power and discourse. In Chapter 4 I detail further Foucault's understanding of authority and power and how authorities exert power over people through the surveillance and monitoring of bodies, as well as how people come to monitor their own bodies.

In the next section I consider how practices, both rational and symbolic, can act to 'control' this 'danger' posed by the liminality of grief. But first I want to consider how people might continue an embodied connection to a person after they die, as it is 'holding on' to the deceased that bereavement researchers have identified as the

problem in need of professional intervention and management among bereaved people.

The continuing bonds theory, discussed in Chapter 2, was first proposed as an antidote to theories that emphasised detachment from the deceased as the way to resolution or recovery. However, I argue the continuing bonds theory tends to rely upon the individualised and largely disembodied subject it attempted to critique. Ribbens McCarthy and Prokhovnik (2013) similarly have critiqued the notion of 'internalising' the dead person that the continuing bonds theory describes, contending that it remains predicated on the mind/body split by psychologising and locating the deceased other within the individual's psyche. Instead Ribbens McCarthy and Prokhovnik recommend the need to move beyond the binary thinking that is implied in models such as the continuing bonds theory to think about how people maintain a material and embodied relationality after death.

Ribbens McCarthy and Prokhovnik highlight how within a western secular framework that assumes the mind/body and life/death divide, it is unclear what happens to personhood following the death of the body. However, for Ribbens McCarthy and Prokhovnik while the biological body dies, the embodied relationship does not. The material presence of the dead person remains as well as the 'us' formed in the relationship between the two bodies. This 'us' remains written in the body of the living person as an ongoing embodied presence. In contrast to the disembodied continuing bonds theory, Leichtentritt et al. (2016) in their qualitative study found that bereaved people made attempts to blur the boundary between living and dead bodies, 'by focusing on physical aspects of the post-death relationship using their own body as well as that of the deceased' (p. 5). The exploration of the ways in which the

bereaved person experiences the presence of the deceased in their absence has led a number of authors to consider the notion of 'absence-presence', positioning the grieving person at the boundaries between the living and the dead and blurring the edges of the bounded subject (Frers, 2013; Maddrell, 2013; Meier et al., 2013).

An embodied approach focuses on how absence becomes not only something to be dealt with through individual psychic work but shifts bodily orientation in space. As Krasner (2004) argues, grief is a 'series of slight physical adjustments based on the fact that a body that was always here, in a certain relation to our own, is now gone' (p. 219). Grief is the experience of the absence of a body by which one was once orientated and constituted. For Krasner grief has a disabling or crippling effect as the particular physical relation in space has been disrupted. He illustrates this through reference to literature and descriptions of people stumbling, reaching out and falling in the face of grief. Bodies become compromised in grief and have to renegotiate themselves in space.

Krasner describes how grieving can be considered a bodily disposition because bodies are already in relation with each other in varying degrees of intimacy. The experience of absence is rooted in the corporeal 'embeddedness' of people. Absence emerges because bodies are already in a state of 'being-in-the-world' with others, whether human or non-human (Frers, 2013). Frers further explains that, to experience absence, the object must have already been part of the person's 'habitus'. Here, Frers draws upon the concept popularised by Bourdieu (1990). Habitus is a generative form of identity where the social is internalised into the body consciously and unconsciously, which creates a set of ever evolving bodily dispositions, practices, habits and tastes. As Krasner illustrates, this habitus is disorientated in the event of

loss. The presence of absence is the disruption of expectations, a disruption that is experienced bodily and in space. This idea was also captured in Parkes' (1972) concept of the 'assumptive world' that describes how what is lost following bereavement is not only a person but the sense of reality from which the bereaved person made assumptions about world they inhabited.

Arguments that emphasise the embodied nature of grief often do so in opposition to Freud and what is considered to be his disembodied theory of grief. However, I return to Freud to demonstrate how psychoanalytic theories of loss and attachment support a relational embodied concept of the self. As described in Chapter 2, for Freud relationships were fraught with ambivalence due to the way in which people identify with others, where the continuation of one's understanding of oneself was in part or wholly reliant upon the endurance of another object outside of oneself. The loss of the loved object thus brings that ambivalence to the fore. From Freud and Klein's understanding of internal objects and how they come to be internalised, the work of grief is not about 'taking in' what is 'outside' but an acknowledgment that for the object to be lost 'it must have already existed within the subject' (Ahmed, 2004, p. 160).

Butler (2003, 2004, 2010) draws upon Freud's essay 'Mourning and Melancholia', to describe how grief reveals a fundamental human dependency on others. Loss and vulnerability follow from being socially constituted bodies. Yet what grief displays, writes Butler, is that people are in relation with others in ways of which they are unaware, challenging the notion of an autonomous subject who is in control. As was displayed in the last chapter, the work of mourning in Freud came to be interpreted as a discrete process with stages and tasks, yet Butler notes that Freud kept changing

his mind on when mourning is successful. For Butler, Freud's theory instead suggests the ways in which people are liable to 'coming undone' by others. Butler directly attacks the notion in grief theories by arguing that grief is not something that can be 'worked through' but rather something larger than one's plan or choices:

I do not think for instance one can invoke the Protestant ethic when it comes to loss. One cannot say, "Oh I'll go through loss this way, and that will be the result, and I'll apply myself to the task, and I'll endeavour to achieve the resolution of grief that is before me". I think one is hit by waves, and that one starts out the day with an aim, a project, a plan, and finds oneself foiled.
(Butler, 2004, p. 21)

Butler positions the relational subject as the given form of the subject, and in doing so she builds on Freud to explain that dependency rather than autonomy is the fundamental state of human beings, elucidated by the experience and expression of grief. The autonomous individual for Butler, rather than being a reality, is 'an accomplishment, not a presupposition, and certainly no guarantee' (2004, p. 27). Butler highlights that people are not only constituted by their relations with others but dispossessed by them. In this framework 'severing ties' is impossible because the 'I' cannot be thought without 'you'. However, ambivalence arises in the struggle between the desire to grasp control and maintain autonomy and the reliance upon the other needed to exist.

This ambivalence is evidence of the way in which objects become incorporated into the self, but further how people do not precisely know the ways in which they are attached to the objects in which they invest. Ahmed (2010) describes the melancholic

figure as one who does not know what has been lost. Melancholia is not an inability to let go but an inability to perceive what needs letting go of. As in Klein's theory, melancholia arises because the person does not know how to lose (Kristeva, 1989). The presence of ambivalence also reveals a different view of agency where the attachment that sustains life at the same time destroys autonomy. Berlant (Berlant & Edelman, 2014) employs the term 'non-sovereignty' to describe this, invoking the psychoanalytic notion of the subject's constitutive division that keeps subjects from fully knowing or being in control of themselves. Borrowing from Berlant, melancholia and the refusal to recover or let go of attachments to the dead can be read not only as a sign of pathology but understood as an active choice to not be sovereign. This is explained further in Berlant's (2011) concept of 'cruel optimism', which describes how a relation of desire to an object can become cruel by becoming an obstacle to flourishing. Berlant's concept is instructive for grieving for while recovery is constructed on the understanding that detaching from the lost object leads to successful mourning, yet it is the object, as Berlant describes, that is the anchor that sustains hope. So while an attachment to the deceased person might act to impede the ability to 'move on', that same attachment provides a sense of self, and belonging in the world. This is the cruel nature of the optimism for the lost object where the bereaved person is then suspended in the space of liminality, for to let go and leave the object of desire is to leave the anchor for optimism, and yet staying with this fantasy produces unhappiness.

In this section I have discussed literature that has emphasised the body and embodiment in the experience of grief. I have also discussed literature that has enabled me to view the relational and affective aspects of bodies, and the importance of this relational nature for understanding the experience of grief. However, these

bodies are also potentially problematic in a culture that favours autonomous individuals where the boundaries between mind, bodies and emotions are clearly demarcated. From the literature I have discussed in the previous two sections, I argue this is a proposition that is unsustainable and which has led to the shortcomings of the dominant grief theories described in Chapter 2. In the next section I focus on practices as a way to bridge together the two discussions on emotions and bodies, and to centre in on how people are managed, and manage themselves, in the liminal space of grief.

3.2.3 Managing emotions and bodies: affective practices

In this section I argue that a focus on practice can help to resolve some of the shortcomings of the perspectives on affect described in Section 3.2.1, as well bring together ideas on how emotions are embodied in practice. I draw on an argument first proposed by Wetherell (2012) in her discussion of affect theory and emotion and her concept of 'affective practices'. Wetherell argues that the generic category of autonomous affect is unhelpful and that, instead, affect needs to be situated and studied as part of an embodied process of meaning-making. Wetherell also argues for the need not to abandon discourse, as many affect theorists have done, but to explore through an analysis of practice how affect interacts with and informs discursive meaning-making. An analysis of 'affective practices' is thus not one necessarily concerned with following 'flows', but human behaviours that seek to preserve, construct and negotiate identities and meaning.

According to Scheer (2012), a focus on practice in the study of emotions can help to bridge dichotomies between structure and agency. Practices not only generate

emotions but emotions themselves can be viewed as a practical engagement with the world. Practices can be considered as 'vehicles' for emotions or emotions can be considered practices in themselves. Both Wetherell and Scheer use a Bourdieusian understanding of practice. In Bourdieu's (1990) understanding, subjects are not prior to practices but products of them. Bourdieu explained this through his concept of 'habitus'. For Bourdieu the individual internalises the varying conditions of objective social structures and norms producing particular bodily dispositions. These learned behaviours become unconscious and habitual. Practices are then guided by a 'practical sense', which is informed and shaped by the norms and the society in which one lives. Bourdieu's concept provides an embodied understanding of practice as well as an understanding of what might predispose a person to express emotion in a particular way. Bourdieu's model of practice also argues that certain emotional practices, including facial expressions, are learnt or inherited from the society in which one lives, and are not necessarily 'natural' displays of emotion.

Thinking about emotions as practices also repositions emotion as no longer opposed to rationality but as potentially central to rational action (Barbalet, 2001; Turner & Stets, 2005). Barbalet (2001) argued emotions should be understood as essential to social structure and processes, as well as the routine operations of social interactions, where emotions provide direction and give purpose to action. Viewed from this perspective, emotions do not derail rational behaviour but give it meaning. If emotions distract persons from their purposes, then, at the same time, emotions establish those purposes afresh. Barbalet further described how emotions such as confidence and shame serve to produce and maintain social structures, highlighting how emotions can produce change but also conformity and sameness.

Ngai's (2005) description of 'ugly feelings' provides a way of thinking about emotions that are not necessarily transformative or disruptive. Ugly feelings are 'minor' feelings like anxiety or irritation that do not bring about a release or catharsis but rather serve to perpetuate the situation that caused them originally. Thinking about affects that suspend agency is an interesting counter to the authors who write about the transformative potential of affect. I argue it is a useful way to think about the place of the affective in the everyday and how the practices people carry out in the act of 'reproducing life' (Berlant, 2011) are imbued with the affective.

For example, the organisation of the working day has a particularly important role in modern western societies that are governed within a neo-liberal capitalist system (as I argue in Chapter 5). Binkley (2009), drawing on Foucault's concept of 'technologies of temporalisation' discussed how the organisation of time is central to producing 'docile' and obedient bodies. As I go on to describe in Chapters 5, 6, and 7, time has an increasingly significant role in how grief is both defined and treated, with designated time periods marking the line between normal and complicated grieving. As I argued in the opening section on liminality, if grief is an emotion that suspends agency, reintegration and recovery become reliant on time-limited interventions that reorient the bereaved person into a linear sense of time.

The ways in which affective practices are carried out in the ordinary working day is further captured in Hochschild's (1983) understanding of 'emotional labour'. Based on Marx's theory of labour (1976), Hochschild described how waged labour was not only physical but required emotional work. In her study of air flight assistants she explored how the employees traded on smiles and were trained and encouraged to express positive emotions as an unpaid part of their job. For Hochschild these 'feeling

rules' that existed in the workplace were part of a broader emotional management that governed people's interactions in their day-to-day lives, and a form of exploitation. However, when emotional management becomes institutionalised as part of company policy, Hochschild argued this led to a commodification of emotions since what is being sold as part of the service is a display of appropriate emotion. At its simplest, part of the emotional labour was to smile at customers and at its most taxing not to show negative emotions to difficult or abusive customers. Staff thus became alienated from their 'authentic' feelings through the required performance of emotions. These performances were either 'surface acting', where the person pretended to feel an emotion but did not deceive themselves as to their 'true' feelings; or 'deep acting' where the pretence became indistinguishable from the 'true' feelings, causing a transformation in how the individual felt and related to their emotions.

While Hochschild's belief in natural 'authentic' feelings is problematic, her analysis of how emotions are utilised in work practices illustrates how everyday practices become a way of managing the emotions. It also demonstrates the performative nature of emotions. In Hochschild's understanding of 'deep' and 'surface' acting, the performance of emotions can never be understood to be 'real', rather that the real, the unmanaged and spontaneous emotion had to be rescued from the processes of emotional management. Yet I would argue that performance is central to affective practices, and that the performance itself might be considered the 'real' emotion. Goffman (1959) claimed that even the most 'authentic' appearing performances are managed. For Goffman, emotions were just another 'move' in the 'game' of controlling and managing the impression one gives to others. Emotional expression was not about relaying the true character of a person but a response to the requirements of the social encounter. Authenticity was something that was achieved by the

persuasiveness of the performance that required adhering to the 'feeling rules'. Further, for Goffman even those emotions performed in private, in the absence of an audience, were socially performed.

Affective practices can also be studied as a way of understanding how people construct and maintain identity and not only how they might hide or perform it. Valentine (2013) employed Wetherell's concept of 'affective practices' to explore responses to death and bereavement through her analysis of people's narratives about their continuing relationships with the deceased person. Valentine drew on the work on affect to illuminate the role of the body and emotions in managing identities of bereaved and deceased people. For Valentine, affective practices referred to the 'behaviour designed to preserve relationships, identities and continuity of being' (2013, p. 385). Grief provided the epistemological site for exploring how individuals made sense of the mix of ordinary and extraordinary in the experience of bereavement. Valentine described how people managed post-mortem relationships through situated affective practices such as memorialising the dead through formal and informal rituals. These affective practices were a means to repair identities shattered by the event of loss. The practices of meaning-making and continuing attachments to the deceased were not something that simply happened as a result of a psychological state, but arose out of strategic social action (Unruh, 1983, p. 349).

In terms of identity repair following bereavement, there has been a considerable amount of research on how bereaved people use material spaces as a way to actively manage the liminality of grief (Hockey et al., 2002; Horsley, 2008; Maddrell, 2013). These studies have shown the meaning of spaces has a role to play in how death and grief are experienced, not only in the spaces of the cemetery or the funeral home

(Horsley, 2008) where death is expected to be, but also as a site of creativity and agency where the landscape is adapted to accommodate formal and informal grieving rituals, such as roadside memorials. Maddrell (2013) has described in her work on informal public memorials how absence becomes a dynamic 'absence-presence' located in material spaces, not just in the psyche. This forms what she calls a 'third emotional space' where informal memorials serve to mediate between private and public, and between the living and the dead. What these studies have demonstrated is how people come to inhabit spaces such as the cemetery to manage the liminal experience of grief, and further that these spaces too are liminal in that they forge a unique space between the living and dead. However, these spaces also become identifiable places in which to locate the deceased person, and in effect bring some order to what might be felt as the disorientating experience of grief. Here, the dead are not only divided from the living, but they are in effect 'stored' so that the living may here interact with the dead, before returning to their lives away from this socially designated space of bereavement and death.

Affective practices can be seen as everyday performances and behaviours that emerge in response to social encounters or events, performances that might be differently interpreted as conforming to or resisting the dominant 'feeling rules'. Affective practices are also important modes of preserving and maintaining identity, where identity is something constructed through everyday actions not something occurring inside the individual psyche. Describing emotions as practices, I argue, is a way to overcome the problems of viewing emotions as uncontrollable intensities that come from 'outside-in' and equally the difficulties in arguing for a set of basic emotions that emerge from 'inside-out' of the body. It also allows space to reconsider the important role of discourse in constructing ideas and norms around appropriate

emotional behaviours. Following Bourdieu's notion of practice, emotional expression is understood as a learned and habitual bodily practice and not something that is merely repressed or induced by feeling rules, as in Hochschild's argument. The management of emotions can be thus understood as more akin to Foucault's (1988) 'technologies of the self' where individuals act to govern their own behaviour for different ends through various practices (a concept I describe further in Chapter 4). In the Chapters 5, 6, and 7 I focus on different types of practices that seek to manage grief, often in order to achieve the end goal or recovery, but I also highlight practices, such as interacting with spaces and objects, that act to preserve and construct identities both of the bereaved person and the person who had died.

So far in this chapter I have drawn on literature that has differently emphasised the intertwined nature of emotions, bodies and practices or rituals that combine together to produce different experiences of grief. In closing, I now turn to consider what type of body or subject emerges from this way of conceptualising grief, as opposed to the autonomous resilient individual that recurs in the overly psychological view of grief described in Chapter 2.

3.2.4 Theorising 'the blob'

In speaking of affective practices it might feel as though a conscious, rational actor has replaced the ambivalent melancholic figure discussed in this chapter. Yet to emphasise the analysis of affective practices is to move away from categories that govern and constrain behaviour to thinking about how the category of an emotion does not determine the actions and feelings felt in its wake. I argue a focus on practice can allow for the study of grief that acknowledges that people might come to inhabit

the structure of grief differently, conforming to or resisting feeling rules.

In this attempt a quite different, yet unclear vision of the bereaved person and grief emerges. The body is both material and beyond materiality, coherent and emotional, possessing the capacity to be affected by others and also to remain resistant to them. This understanding of the body as always in flux is made possible through a relational ontology of the body. This resonates with Deleuze and Guattari's (1984, 1988) 'nomadic' form of subjectivity where the body is viewed as a constant process of becoming. The nomadic subject has 'no terminus from which you set out, none which you ought to arrive at' (Deleuze & Parnet, 1977, p.2). The aim of the nomadic subject is not integration but rather disintegration, captured in Deleuze and Guattari's concept of the 'body-without-organs' that poses a radical counter to the question of 'being this or that sort of human' (Deleuze, 1990). The 'body-without-organs' describes a subject not constrained by binaries, whether the divide between the living and dead, or the mind and body.

While Deleuze and Guattari seek to affirm the potential of the human body and liberate it from what they see as unnecessary boundaries, as the name suggests, the 'body-without-organs' views the material matter of the body itself as something from which to be freed. This is often where the disembodied accounts of affect heavily influenced by Deleuze and Guattari derive. However, is there really nothing to be said for the human body? This is the question Bloch (2013) posed as he attempted to account for how people can be both in process and relational beings and yet also have some type of biological consistency that makes people identifiably human. Bloch begins his essay by describing the 'universalist vs culturalist' debate that has plagued the history of the social sciences in the attempt to define 'human nature'. Critiquing

the social construction of the culturalists, Bloch argued that in the attempts by the social sciences to capture the 'individual' and 'self' there has been a failure to consider people as natural organisms. Bloch then proceeded to propose a model of the human which, to avoid the ontological underpinnings of categories such as 'self', he called 'the blob'. The 'blob' is created simultaneously by biology, psychology, history and culture. Bloch's model of the blob is an attempt to reconcile the ideas of the social sciences, namely anthropology, and those found in the life sciences and to explain the multiple and incomplete visions of the human that are produced when in 'the never-never land of culture without minds and bodies' or in 'the never-never land of minds and bodies without culture and history' (Bloch, 2013).

Bloch distinguished three different levels that compose the blob. The three levels exist on a continuum, where neither element can be separated from the other.

- The 'core self': This involves a sense of ownership and location of one's body and a sense that one is the author of one's own actions. This is a type of selfhood Bloch suggests is shared by all animate creatures, but implies no reflexive awareness whatsoever.
- The 'minimal self': This concerns a sense of continuity in time. This level involves the short-term memory required to organise episodes and the ability to use information from the past to inform behaviour in the present and the future.
- The 'narrative self': It is the narrative aspect of the blob that allows memories to be formed into an autobiography. However, having an autobiography is distinguished from being conscious of and using language to speak about one's autobiography. Bloch here makes a distinction between two rhetorical styles:

those that tell stories about themselves and those that do not.

Bloch makes this point concerning the 'narrative self' to emphasise that this does not imply a difference in the nature of the blob but rather a difference in style and means of expression. It is here that culture has a clear role to play in shaping the type of stories people might tell about themselves. Yet as Bloch points out it is not possible to say how much influence culture has until the epistemological status of the thing claimed has been clarified. I find Bloch's analysis greatly useful for conceptualising of the self without having to fall on one side of the 'universalist vs culturalist' debate. Here, mind and bodies are on a continuum, and emotional expression is both bodily and socially informed: there is no way to distinguish them from one another.

The paradox of grief then can be viewed as a paradox embodied by humans themselves in that biology and the environment (including other people, language, social norms and social structures) one is situated in are always in negotiation. This shape and form does not exist prior to this negotiation, at least only in the form of the blob that allows such negotiation with the environment to be possible in the first place. In Chapter 4 I describe further how I am theorising subjectivity in this thesis, drawing on the Foucauldian ontology that suspends judgment on the 'nature' or essence of the human body, exploring the questions of how people account for themselves rather than asking what people are.

3.3 Conclusion

In this chapter I have tackled two areas of concern that I argue have been largely

overlooked in past and present research into grief and bereavement. As discussed in the Chapter 2, much grief research rests on the assumption of an autonomous individual subject and the belief in grief as a natural emotion. Through this a paradoxical grieving figure emerges that is at once a rational and resilient actor and yet liable to 'come undone' by the loss of another. I argue that the study of grief has been short-sighted in its understanding of emotions and bodies, and I have turned to literature from the social and cultural sciences to bring new insight to theorising grief. In this attempt I have highlighted the 'unbounded', relational and unconscious aspects of the body as well as explored how emotions might not be understood as things one innately has or 'catches' from elsewhere but something one does through practices, whether extraordinary or mundane, which give form both to the affect and to the body itself. By centring the discussion on the concept of liminality my aim has been to suggest that theorising grief is best begun with no 'a priori' assumptions of what constitutes grief and the person who experiences it.

In reviewing this literature, I have also addressed, as Hockey et al. (2010) have done previously, the impasse between social constructionist arguments that claim human beings see and experience their environment in culturally specific ways and the everyday experiences of the immediacy of bodily emotional and sensory responses to that world. I argue that biology and the social environment are in a constant process of interaction, out of which the shape of the person and their grief comes into view. In the next chapter I outline the methodological foundation upon which I base these theoretical claims on the subjectivity and the emotions. I explain in detail the methodological perspective of Foucault and how his way of understanding how knowledge and subjectivity is constructed reinforces the central role of practice to the study of bodies and emotions.

CHAPTER 4

Methodology and Methods

4.1 *Introduction to the chapter*

In Chapter 3, I challenged what I argue are dominant notions in popular understandings of grief and recovery. In challenging these assumptions my intention was to propose a different way of conceptualising both grief and recovery. Here I detail the methodological approach that underpins my understanding of grief. I draw on the work of Foucault (1970, 1971, 1984a, 1984b, 1984c) and the Foucauldian approach adopted by Rose (1985, 1989) to consider grief not as an identifiable entity but as a historically constructed object. In the first section of this chapter, I introduce the methodology of Foucault and how I adopted a Foucauldian approach to the study of grief and recovery in a contemporary UK setting. I focus on the themes of 'problematisations', 'explanations', 'authorities', 'technologies' and 'subjectivities' to unpack the key elements of a Foucauldian approach.

In the second section, I detail the methods I used in my research. I undertook a qualitative approach, comprising document analysis of policy and lay literature and 27 semi-structured interviews. A qualitative approach was well suited to a Foucauldian theoretical stance in that it allowed me to explore how grief and recovery were defined, practiced and constructed by different individuals and groups. By using document analysis and semi-structured interviews, I sought to capture how both 'expert' and 'layperson' defined grief and recovery, and the practices involved in the management of grief and recovery. I also present information on the participants

in the study and the ethics of accessing 'vulnerable' groups. I emphasise how carrying out qualitative research is a process by reflecting on the ethical boundaries of the interview encounter and how I managed my own subjectivity through maintaining a reflexive approach.

4.2 Methodology

In Chapters 2 and 3 I reviewed the dominant and alternative explanations of grief in past and contemporary literature. In particular, I critiqued the assumption underpinning much of the literature - that grief is an identifiable entity that can be located within the individual psyche. Though interpretations of grief vary along a spectrum from a biological reaction to a socially constructed category, there remains a dominant belief in grief as a natural response to loss. As a result, research into grief begins with an assumption that grief is 'universal', 'natural' and 'normal'. I argue that two problems arise from this assumption. First, when grief is presumed to be present in all people an apparent lack of grief at the level of an individual becomes cause for concern. Research, then, becomes structured around identifying and remedying those grief reactions that deviate from the presumed natural expressions of grief. Second, recovery also becomes standardised. Again, deviations from a 'normal' course of grief stand out and can be identified by those charged with the responsibility of surveillance. Attention is given to encouraging people along a particular course of recovery based on the understanding that recovery is desirable, and the failure to recover is either a sign of resistance or failure of individual will.

For Foucault, a methodological approach begins with the understanding that one

cannot assume there is anything fundamental about phenomena like grief or more broadly about people and the society within which they live. From this perspective, people who experience ‘complicated grief’ are not resisting a natural course but transgressing social norms and dominant discourses around what ‘normal’ grief is considered to be. In Foucauldian terms ‘normal’ is not universal but historically situated. It is this destabilisation of universal assumptions about people and society that is the starting point for any Foucauldian analysis. Building on the work of Foucault, Rose (1989) identified a number of areas of focus in a Foucauldian analysis: ‘problematizations’, ‘explanations’, ‘technologies’, ‘authorities’, and ‘subjectivities’. I use these terms as a guide to elucidate the methodological framework within Foucault’s work. I begin by defining each term.

4.2.1 Problematizations

To focus on ‘problematizations’ is to question why certain ideas, practices or people might emerge as a ‘problem’ in a particular time and context. Foucault’s *History of Sexuality* (1976) traced how sexuality had been viewed, repressed and liberated over time. In doing so, Foucault revealed that ideas or people become problematic not because of something inherent within that person or idea, but because of how it/they might pose concerns of a moral, political, economic, military or juridical nature. Therefore, analysing problematizations involves asking why something or someone comes to be identified as a problem at a certain point in time. It also involves acknowledging how problems emerge *in relation* to other sets of interests. As a consequence, revealing that problems are contingent on their relation to a particular political, moral or economic context suggests that things could be otherwise. In this methodological approach, the aim is to destabilise the present and its taken-for-

granted certainties, in such things as institutions (i.e. the prison system or similar orders) and ideas such as sexuality and its underpinning moral code.

Thus, destabilising the present can foreground alternative ways of conceptualising those ideas or persons that might be viewed as a 'problem'. In doing so, less dominant ideas come into view. As discussed in the Introduction, it was the question of what happens to people who do not recover from grief, which drove my inquiry into what comprises recovery and how grief is defined. In the 1961 Preface to *The History of Madness* (2009), Foucault wrote that his intention in the work was to write 'an archaeology of silence' that had been created by the language of psychiatry. The translation of madness into mental illness for Foucault meant there was no longer a common language in which the 'madman' could communicate with 'modern man'. In other words, the languages were incommensurable. This rupture in dialogue allowed psychiatry to emerge as the means to explain madness in terms of mental illness. Similarly, I argue the story of no recovery, the non-recovered, is a story hidden from view, its silencing limiting the possible alternatives and scope of recovery.

How does a story become hidden and how can it be made visible? Foucault claimed that 'truth' was not absolute but multiple. Rather than seeing objects or identities as singular, they can comprise multiple 'truths' - often *produced* at the intersections of different discourses. Foucault disregarded any universal notion of truth, because he argued that universal understandings are historicised, and examining the ways in which they are constructed and emerge out of a particular historical context reveals this 'truth' fallacy. Put simply, truth is historically located and socially constructed. This characterised Foucault's largely 'genealogical' approach to research, which involved building a 'critical history' of an object or phenomenon. For example,

Foucault took the birth of the modern clinic (1963), the prison (1975) and sexuality (1976) as objects of study and explored how they became institutions, with what purposes, and into what forms and with what rationality. In this way Foucault explored how 'truths' about people or objects and ideas were constructed, but his line of enquiry went further than simply stating that truth is socially constructed, as Rose (1989, p. x-xi) described:

It is not very enlightening to be told repeatedly that something claimed as objective is in fact 'socially constructed'. Objects of thought are constructed in thought, what else could they be? So the interesting questions concern the ways in which they are constructed. Where do objects emerge? Which are the authorities who are able to pronounce upon them? Through what concepts and explanatory régimes are they specified? How do certain constructions acquire the status of truth - through experimental procedures, demonstrations and other interventions?

For Rose, this line of questioning begins by problematising what is taken to be truth and then looking at who is making claims to truth and with what explanations. Further, in Foucault's argument power is no longer maintained in a direct line, such as that of a king to a prince. Rather, truth claims, that is to say knowledge, becomes power. A genealogical approach is not a search for 'origins' or 'truth' but rather how ideas come to be seen as true. The object then emerges into view through explanations, technologies and authorities, as I outline next.

4.2.2 Explanations, technologies and authorities

A key focus of this thesis is to explore and interrogate the cultural discourse around grief. The term 'discourse' refers to a body of statements that are arranged in a systematic pattern of organisation. The pattern of discourse is formed by rules that designate which statements fulfil the conditions to be part of the discourse. Therefore, studying discourse is not about taking the perspective of the person who is speaking but rather is about looking at what the discourse does, what rules it enacts, and how these rules serve to exclude or include. The knowledge of a specific group of people (such as people who have been bereaved), or of a subjective state (such as grief) is shaped and defined by the dominant discourses, and is what counts as knowledge. In Chapters 5, 6 and 7, I present data findings and describe a number of different discourses people drew upon to make sense of grief, including therapeutic, psychological and political discourses. Grief discourses produce *explanations* of grief. Studying discourse involves exploring how some explanations come to hold precedence over others. As I discuss in Section 4.3.7 this involves analysing the type of language and 'operative concepts' used. It also includes exploring how and by whom explanations are accepted and proved. In Chapter 2, I began this by highlighting the explanations used by psychologists and how they were accepted over and above other theories of grief. Discourse incorporates not just language but also the assumptions made within explanations, and the type of logic or mode of articulation.

The dominance of one explanation over another that forms a particular discourse around grief is shaped by who has the *authority* to make a claim about grief. In a Foucauldian line of enquiry the aim is to explore how authority is constituted and

what procedures are used to acquire and maintain authority. Further attention is directed to alliances and conflicts between different types of authorities. Authority is not accepted as 'true' due to its adherence to a particular framework whether legal, religious or psychological, but questioned for how it became established so that it could claim authority over a particular phenomenon. For instance, with grief and recovery as my object of study, in Chapter 2 I questioned why psychology had taken such a dominant place in providing an explanation and establishing a public discourse around grief. Discourses on grief and recovery are thus intertwined with power, and who has the power to make a claim to knowledge about grief, which Foucault called 'truth claims'. However, in Foucault's theory, contrary to some interpretations, Foucault argues that power is no longer merely exerted from an authority above to the people below, but emerges in relations between individuals and groups. This is illustrated in Foucault's concept of 'governmentality'. Governmentality refers to how the conduct of people is governed by a number of different authorities whether of a psychological, political, economic, or juridical nature to achieve a particular aim, for example, in this case, recovery. Foucault developed the concept as a way of identifying certain rationalities of government and how they permeate across authorities, political and personal, through 'régimes of truth'.

The types of *technologies* used by authorities is also an area of focus within the Foucauldian approach that explores what apparatus, interventions, strategies and forms of measurement are used in judging the object of study. Within the literature on grief, I described how grief came to be measured by psychological testing, or diagnosable by a psychiatric manual (DSM-5), and treated with bereavement counselling. These are all technologies developed and utilised by authorities that are seeking explanations about grief. For instance, I used the accounts of bereavement

counsellors and support workers interviewed in this research, to explore what claims they were making about grief and, importantly, what sort of interventions, activities or practices then take place on the basis of this 'truth' about grief. As touched upon in Chapter 2, certain interventions or technologies are used depending on how grief is interpreted. Psychological technologies become appropriate when grief is viewed as a matter of the individual mind that is measurable and can be categorised as normal or abnormal. Crucially, the technologies also transform the object of study in the process. In Foucauldian thought technologies are not judging an object that exists independently or in 'nature', but it is through the act of naming, measuring, and categorising that an object becomes visible, constructed in relation to the authorities that seek to make claims about it. In other words, the act of measuring is formative of that which is measured.

4.2.3 Subjectivities

In the same way that a genealogical approach seeks to problematise ideas, Foucault rejected the idea of starting out with a theory of the subject (1984c, p. 290). Foucault's study of human subjectivity encompassed the *ontological* (the nature of human beings); the *epistemological* (how the subject is known); *ethical* (the type of selves people should seek to be), and *technical* (the forms of conduct and practices people undertake in order to achieve desirable traits). In terms of the ontology of the subject, Foucault's work focused on effacing the particular image of 'man' that had dominated western history, rather than assuming a materiality behind it. For Foucault the subject was not a 'substance' but a 'form' where the body was to be understood not as a brute fact of nature but as a historical entity. A genealogy of subjectification takes a particular understanding of the human as the site of a

historical problem rather than as the basis of a historical narrative. What aims to be revealed is not a universal nature of the subject, but rather the multiple forms of knowledge that are constructed around the subject. These different forms of knowledge 'arm' the subject with a truth that does not reside within (Foucault, 1984c).

Rather than composing a history of the person, the aim is to construct a genealogy of the relations to the self. This is achieved by focusing not on revealing the 'truth' of the subject but highlighting the ways in which 'one plays' at constituting oneself in different situations and contexts. In the course of detailing how different bodies are produced and managed, the body emerges as a contested site, not a constant but shaped and manipulated by different contexts. Subjects are constituted into various forms through an ethical relation to the norms and games of truth that govern a particular historical context. This production of identities Foucault described as the process of subjectification. Deleuze (1990) described the process of subjectification as the relationship to force or power that, depending on where the line is folded, establishes different ways of existing. It is within these 'folds', as Deleuze puts it, that the 'self' emerges.

Subjects are not, however, merely formed by forces of power but develop as 'ethical' subjects through the ways in which people come to relate to themselves. Foucault (1988) described how people turn to work on themselves through practices he called 'technologies of the self'. 'Technologies of the self' refers to the ways in which individuals experience, understand, judge, and conduct themselves. Foucault explained that 'technologies of the self':

(...) permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thought, conduct, ways of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, immortality. (1988, p. 18)

Foucault's explanation of power allows for the understanding of how people govern themselves in the promise of transformation into a happier, purer and wiser self. Power, in Foucault's terms, is thus productive rather than merely repressive; the presence of power produces identities as opposed to repressing them. Furthermore, the 'governing of the self' changes how people relate to themselves. People work on themselves through different 'bodily régimes', for example, carrying out 'grief work' as described in Chapter 2. The management of abnormality, which is the focus of these technologies, is carried out not only by authorities but also by the individuals themselves, as they are encouraged, in Foucault's view, to become 'happier' or 'recovered' in the name of becoming ethical subjects.

One of the metaphors Foucault (1975) used to illustrate this mode of self-surveillance was the 'panopticon'. The panopticon was an architectural design created by Bentham in the mid-nineteenth century and built in prisons, mental asylums and factories. Within prisons, the building of the panopticon allowed for prisoners to be constantly observed, and yet while the prisoners were aware of being surveilled they could not see who was observing them, nor could they see their fellow prisoners. For Foucault, this represented a new form of discipline and power that was gained through the monitoring of peoples' behaviour, rather than through directly repressing peoples' actions. Further, under the awareness of being surveilled, people

acted in accordance to the rules demanded of them. This self-governance acted as an extension of power - a power that was achieved by the possession of knowledge - derived through the observation of people.

4.2.4 Studying subjectivities

For Foucault there is no true ethical human subject: the subject is created, and is contingent on the historical context. The idea of what a subject is depends on the prevailing discourse and explanations provided by the relevant authority at a given time. In this thesis I am tracking the grieving subject and the different forms grief takes whether 'complicated' or 'recovered'. This subject, I contend, in line with Foucault's work on subjectivities, does not exist as a material reality apart from the way it is constructed by discourses and practices on grief and recovery. I describe 'figures' of grief, where I refer to representations of types of grief. These representations are public, cultural figures, promoted by media, literature or political discourse, and that come to impinge on the type of person the bereaved person might judge himself or herself to be. I view individual identity as a construction that people come to inhabit. Identity is a collaborative construction in that it is not formed purely through individual choice, which would presume an autonomous self-determining subject (Giddens, 1991), but identity is formed by interaction with other people and social structures. In this view I am applying Foucault's conception of subjectivity as something that emerges through negotiation with authorities and discourse, and through incorporating relational models of the self as discussed in Chapter 3, leaving space to consider how people come to make choices about their identity, and the extent to which those choices can be seen to be 'conscious' or 'unconscious' ones.

As discussed in Chapter 3, 'subject', 'figure', and 'individual' are terms that attempt to describe people, but also refer more to cultural expectations than anything decisively 'human'. In this thesis I seek to avoid the connotations that are attached to terms like 'individual' or 'subject' and use them only to highlight their use by participants in my data. I use the term 'person' in this thesis, albeit tentatively due to what I argue is a socially constructed notion of 'personhood'. What constitutes a person has varied historically and remains a contested notion in areas such as law and philosophy. I use 'person' as it is a term more commonly used by both the participants in my study and the literature I have analysed and further to avoid over use of the unfamiliar and also potentially problematic term 'human'. What constitutes a 'person' or 'human' remains a question I seek to interrogate in this thesis.

Foucault received consistent criticism, particularly from feminist scholars, due to what was considered 'gender blindness' in his conception of the disciplined body, arguing that he overlooked how different bodies experience the world (McNay, 1991). This argument points to the larger absence of human agency in Foucault's writings. This arguable absence of the materiality and agency of the human body can be viewed as an effect of how Foucault sought to decentre the embodied subject as the starting point of theory. By contrast, feminist methodological approaches utilised autobiography to argue against the disembodied objective stance of theory, positioning the experiencing subject and their story at the centre of the formation of knowledge (Ramazanoglu, 1992; Stanley, 1993). From this movement towards embodied theory arose research and theories that placed the body and the personal at the centre of theory, with the aim not being dissimilar to Foucault's, that is, to destabilise the established and overly masculine domains of thought that had maintained the divide between the subjective and the objective, and the body and the

mind.

This approach to an understanding of subjectivity also applied to my own subjectivity as researcher. The identity of researcher demanded a particular 'conduct' and to perform in a particular way. In Section 4.3.3 below, I reflect on how I negotiated my own and my participants' subjectivities during the research. In this process I found Spivak's (1988) description of 'unlearning your privilege as loss' especially instructive. Unlearning one's privilege as loss means acknowledging the limits of one's perspective. Feminist research (Bradotti, 1994; Byrne, 2003; Stanley, 1993; Williams, 1993) has argued that all claims to objectivity are based on partial perspective, and that all knowledge is situated. Recognising the 'situatedness' of knowledge entailed identifying the extent to which the position of researcher limited analysis. What makes up the position of researcher and what might impact the interview encounter is multiple: gender, age, ethnicity, educational status, experience of grief and loss, disability or illness, relationship status, epistemological and ontological perspectives – to name but a few. Becoming aware of 'privilege' involved vigilance to such categorisations, as well as being aware of one's body and the affects it might produce. Such vigilance, I argue, is mandatory for any sociologist, who one would hope might be somewhat more attentive to the role such categories play in constructing identities in social interactions. This is what Bourdieu (Wacquant, 1989) called the 'sociology of sociology' where the social researcher analyses how they conduct and carry out their sociological analysis through taking a 'second step back' and deconstructing the position of researcher. This type of analysis of one's position and privilege as researcher was emphasised in the 'reflexive turn' within social research, which highlighted and critiqued the influence of researcher subjectivity on the collation of data. I describe my own experience of reflexivity in the research

process in Section 4.3.6.

4.2.5 Qualitative methodology

The psychologists and psychiatrists who carried out the most prominent and influential clinical studies in grief and bereavement often used quantitative survey methods to gather their data on grief and results are presented in statistical form. As I argued in Chapter 2, these tools served to produce a model of grief that failed to capture the diversity of bereavement experiences. Law (2009) has argued that methods are performative in that they generate realities and not only describe them. I was aware that my choice of method would influence how I viewed my object of study, and further what forms of 'truth' would become visible in my choice of analysis. A qualitative approach provided me with the capacity to have reflexivity about how I was positioned toward my object, and to remain vigilant to how my choice of method was revealing as well as concealing various 'truths' about grief.

I chose to use qualitative methods as I aimed to challenge some of the dominant theories of grief. I argue popular theories and models of grief assume grief as a 'thing' that already exists 'out there' where the aim of the researcher is to seek new modes of uncovering, quantifying, measuring and categorising grief. By contrast, a qualitative approach can provide the scope to think about how grief and recovery might be differently formed and articulated, as well as how definitions of grief and recovery emerge. A qualitative approach thus allows the researcher to question the taken-for-granted categories and to explore the ways grief, for example, is socially constructed in order to generate new theoretical perspectives on the topic of study. I argue that using a qualitative approach was the best means of fulfilling one of the key aims of

this thesis, which was to highlight what happens when people 'fail' to recover from grief. Further, qualitative methods aim to capture the experience of the individual or group and to discern what is happening in the practices, thoughts and feelings of people's lives (Charmaz, 2004; Silverman, 2005). I wanted to map out the 'liminal space' of grief and explore what was going on in bereavement care and practice and how people experienced the space of grief. A qualitative approach allowed for the analysis of individual experiences and to acknowledge the interactions between individuals and groups.

Qualitative methods include the use of interviews, observation, document analysis and focus groups to explore how people construct meaning from the world around them and make sense of their experiences (Rapley, 2007; Silverman, 2005). I used semi-structured interviews and document analysis. In gathering a variety of documents I wanted to explore the ways in which grief was defined and interpreted from different perspectives and to some extent, how they changed over time. The use of documents complemented the Foucauldian approach I had adopted by exploring the written discourses around grief and recovery, as well as examining how the management of grief was linked to governmentality, for example through the analysis of government policy. I also carried out semi-structured interviews to explore how the discourses around grief and bereavement were conducted in practice and everyday life. In this respect my methodological approach here departed from a traditional Foucauldian analysis by the addition of empirical methods to elucidate how discourse was negotiated in individual accounts.

Qualitative interviewing aims to capture people's experiences, opinions and feelings in their own words. In conducting the interviews I was interested in how different

individuals made sense of grief and their views on recovery. The aim of conducting interviews was not to capture the pure 'reality' of grief and recovery but to gather different interpretations of grief from a variety of viewpoints and to analyse how they agreed with, conflicted, or contradicted the broader public discourse around grief and with one another. Similarly to the approach of Mol (2008), I aimed to treat participants as co-researchers, as ethnographers in their own right. Mol (2008) in her study of a diabetes clinic in the Netherlands, sought not only the opinions but also the events and activities in which patients were involved. The interviewees' accounts extended the observation by informing Mol and her fellow researchers of situations of which they 'had no time or licence to go' (2008, p. 11).

4.3 *Methods: How the research was carried out*

Here I describe the methods I used in this research and how and why they were suited to the nature of my inquiry. As outlined in the previous section, my aims were formed by 'problematizing' grief and recovery and focusing on 'explanations', 'authorities', 'technologies' and 'subjectivities'. To explore these themes I took a qualitative approach: analysing documents and conducting 27 semi-structured interviews. In exploring the perspectives of two different groups, i.e. the 'expert' bereavement care professional and the 'layperson' who had experienced bereavement, my aim was to identify the different interpretations that came to bear on grief and recovery. In carrying out the research my focus was on exploring the following four questions:

- How are grief and recovery defined in both expert and layperson accounts?
- How are 'complicated' forms of grief identified?

- What sorts of practices are undertaken to manage grief?
- What course of action is taken if a person appears to be struggling to recover from grief?

Within these questions the focus was broadly on three themes, that of *meanings*: how people made sense of grief, and *practices*: how grief was managed, which in turn had an effect on the type of *identities* people came to inhabit. The interwoven nature of *meanings, practices* and *identities* I describe are supported by a Foucauldian approach to study where the focus is on three areas: of how ideas come to be 'truth', how practices and discourses establish objects in certain ways, and how people come to be identified as particular types of 'subjects'.

4.3.1 Mapping the field

The first part of the field work was the collation and analysis of a variety of documents and texts that framed ideas on grief and recovery. I saw this process as one of generating an 'archive' (Rapley, 2007) that allowed me to begin to map out the current state of bereavement care services across the UK. Gathering the various documents therefore enabled me to identify the key organisations and individuals that I wanted to approach to participate in the study. The documents I selected were all public documents and I analysed them to understand both what the public perception of grief was across different 'authorities' and how grief and recovery had emerged in particular forms. These documents included:

- UK government policy documents on mental health, bereavement and end of life care
- Bereavement charity/NGO literature

- Autobiographies and biographies
- Fiction
- Poetry
- Newspaper and magazine articles
- Media coverage in news organisations such as the BBC
- Online blogs, forums and websites

The policy documents were selected largely from 2001 onwards, as 2001 saw the publication of the first mental health care policy focused explicitly on recovery (Department of Health, 2001). Other literature was chosen due to its popularity and prominence, for example memoirs that had won awards (Coutts, 2014) or were continual bestsellers (Didion, 2006). My interest in the happiness agenda and the recovery model began in 2010 at the peak of interest in happiness, and I had collected numerous news articles and media items along with related policy documents and government-funded research. This archive which I accumulated ‘as it happened’ helped form the backdrop to the story I chose to tell in this thesis.

In Section 4.3.7 I describe in detail how I analysed the documents along with the interview data. From my document analysis, what started to become apparent were the different ways grief had been framed by various authorities. In a context of government and economic policy focused on well-being and happiness, negative emotions, depression and mental distress were framed as something from which to recover. Further within grief and bereavement research and practice there was a growing interest in researching and categorising complicated and prolonged forms of grief, as I described in Chapter 2. In carrying out the interviews I wanted to explore

the extent to which grief and bereavement care in England was being shaped by these two discourses, of a government agenda to improve the nation's happiness and a move to medically diagnosing problematic forms of grief.

4.3.2 Ethics of researching grief and bereavement

Following my 'mapping' of the field, I sought ethical approval from The Open University Human Participants Research Ethics Committee, including in my proposal the organisations to which I intended to seek access to participate in the study. The Open University Human Participants Research Ethics Committee approved this research on ethical grounds (see Appendix 1.1). I also sought and received ethical approval from other organisations: the NHS Research ethics committee, Cruse Bereavement Care, and St Christopher's hospice (See Appendix 1.2, 1.3 and 1.4). Each organisation had their own ethics approval process that I followed before collecting data.

In carrying out research into grief and bereavement I was aware of the heightened importance of effectively managing sensitive issues that can arise, particularly when encountering vulnerable groups, as many researchers have discussed (Rowling, 1999; Stroebe, Stroebe, & Schut, 2003; Valentine, 2007). As Parkes (1995) noted, bereaved people and especially newly-bereaved people are vulnerable, often experiencing strong emotions. Parkes further claimed that bereaved individuals are vulnerable and thus may have 'impaired judgment' or be unable to concentrate or appraise risks (1995). I find such claims regarding bereaved people problematic. When people are described as vulnerable, to what and to whom are they vulnerable? Certainly sociological research does not set out to exploit or harm anyone in any way, yet the

question of vulnerability is an interesting one, for it suggests that in some circumstances people are vulnerable while in others they are not. By labelling someone as vulnerable and their view as 'impaired', I argue, acts to silence voices by deeming them to be not rational enough. As Ramazanoglu (1992) contends, 'criteria of validation which effectively silence subordinate ways of knowing are methodologically inadequate' (p. 210). Moreover it implies the researcher is immune to vulnerability him or herself, coherent in the face of the 'impaired' participant.

Following Mol (2008), I am of the view that everyone is vulnerable, both participant and researcher. Further, as Renzetti and Lee (1993) described, all research has the potential to be sensitive, and so sensitivity should not be used to describe only particular groups or approaches to research. Often such fears over the sensitivity of research can lead researchers to find they begin to 'edit' themselves out (Valentine, 2007). The fear of enacting harm through the intervention of the interview can mean the researcher's body begins to disappear in the chase for elusive objectivity. The rigour of the ethics committee, though designed to carry out the important role of upholding the integrity of research, can do much to instil fear into the novice researcher. Buckle et al. (2010) have argued there appears to be an incongruity between the experience of those who participate in qualitative research in bereavement who find it to be a largely beneficial and useful experience, and the views of research ethics boards. By being too quick to assume how a research participant might feel there is a lack of accounting for the opinion of the participants themselves.

Investigating the stories that do not get heard, however, carries risks that are not just rhetorical. Over the course of the field work I had to take responsibility for the

accounts of my participants, particularly those who had been recently bereaved, where I felt responsible for any distress that may have been caused by speaking to me about their experiences. In one case, a participant contacted me some time after the interview. It was late evening and he seemed clearly distressed and wanting someone to talk to. I realised the participant had seen me not only as researcher, but due to the personal matters we had discussed, as someone in whom he could confide. I felt weighted with the responsibility of his well-being, causing me a great deal of conflict in the purpose of my research endeavour. I responded by being empathetic but reaffirming the boundaries, making it clear that I could not be accessible to him in this way. I sought advice from my supervisors and informed the gatekeeper, who had put me in contact with the participant, of the incident. The incident made me realise the need to be equipped to deal with 'situated ethics', applying universal standards to individual situations. I had an ethics of care to my participants but in my capacity as researcher my role did not extend to counsellor or caretaker. Learning where the boundaries between the participant and myself were was an ongoing process of discovery and learning, as I describe later in Section 4.3.6.

4.3.3 Recruitment of participants and negotiating access

Carrying out the analysis of documents and texts provided me with a map of the organisations and individuals with a significant role in bereavement care in England. This informed my sampling approach, from which I produced a list of key organisations and individuals I wanted to include in the research. The participating organisations were willing to assist in the research and agreed to forward information to relevant individuals inviting them to participate. I accessed practitioners and clients of participating bereavement services with notices in

information sheets, mailing lists and staff newsletters. I also used social media groups and websites to post information about the research.

Initially I set out to speak with practitioners and clients of NHS bereavement and mental health services and received approval from the NHS Research Ethics Committee in order to do so. However, it became a struggle to engage NHS services with a study of grief. As the research progressed it became apparent that without an 'inside' contact - somebody that worked within the NHS and was willing to expend time to help me access possible participants - that it would prove difficult to recruit people to the study. Meanwhile, I had begun to successfully recruit participants from a number of bereavement care services outside the NHS. Further, a more significant obstacle emerged concerning the topic of my study as I began to approach NHS mental health services. Following an initial enquiry I was told by one hospital that they did not 'medicalise' grief but saw grief rather as a natural event and perhaps I should go and read Freud instead. This experience highlighted the segregation of bereavement services from medical services, and how each condition of normal grief and complicated grief required particular sets of expertise and care from different types of institutions. My enquiry failed as I had failed to recognise the dividing line between normal grief and mental disorder, yet as I argue in Chapters 5 and 6, this division is becoming increasingly blurred in both policy and practice.

This was in contrast to the bereavement charities and services I contacted that welcomed the research. However, some of the organisations were not as willing to allow me to access their clients. For the organisations that were willing for me to offer the opportunity of participation to their clients, I worked with the organisations to ensure that participation was voluntary. For example I was invited to present my

study to the members of a bereavement support group.

The criteria for bereaved participants consisted of being aged 18 or over and having experienced a form of bereavement. When selecting bereaved participants I also looked at the possible 'complications' in their grief, for example I was interested in people that may have become homeless or alternatively had begun hoarding objects as a consequence of bereavement. As a result I accessed participants through routes such as online platforms, for instance I placed an advert on the 'Hoarding UK'⁴ website (from which one participant was recruited); details of my research were provided at a hoarding support group in London (which led to one participant); and the cold weather shelter, partnered with participating organisation Caris Bereavement Service, put me in contact with two previous users of the shelter who had experienced bereavement, and who participated in the study. One participant offered to place information about my research on a closed Facebook group designed to support young widows, which lead to three participants in the study.

My interest in recruiting participants through hoarding support groups or the homeless shelter at Caris was part of my search for people who experience potentially 'complicated' forms of grief. However, this criterion became increasingly problematic, as it was a category neither the participants nor I recognised. Further, as I began to conduct the interviews, the divide between 'lay' and 'professional' became less clear. While I had approached and selected people due to their role (e.g. bereavement counsellor), I discovered that their knowledge of grief was not just shaped by their professional role, and many of the practitioners I interviewed shared with me their own experiences of bereavement.

⁴ The Hoarding UK website: <http://hoardinguk.org/HoardingUK-Research.html> (Accessed 6 June 2016)

In the process of accessing and recruiting participants therefore I met a few obstacles. I believe this was partly due to the way in which bereavement services were organised. Some organisations had set protocols to follow such as completing a detailed form and including the research proposal, which would then be reviewed by an internal ethics committee. Other organisations did not have such procedures in place and were satisfied with the Open University ethics approval. This reflected a fragmentation in the delivery of bereavement support across England and knowing where and how best to recruit participants was not always straightforward. The obstacles I faced were also due to the nature of my research topic, which as I described, was met with questioning when I approached mental health services, rather than bereavement specific services.

4.3.4 Participant information

The participating organisations present examples of bereavement care at national and local level, each with different forms of public support and funding, training and methods. Below I provide further background on the participating organisations:

Cruse Bereavement Care

Cruse Bereavement Care is the largest national charity in the UK dedicated to the provision of bereavement counselling and the training of bereavement volunteers. Cruse's mission, as stated on its website, is to ensure that all bereaved people have somewhere to turn when someone dies. Cruse was founded in 1959 and was originally dedicated to the support of widows (and very different levels of support beyond emotional) but now offers mainly emotional support to adults and children who have experienced any form of bereavement. Cruse support largely consists of

one-to-one counselling: according to their figures 29,803 bereaved people received such support in 2014. Cruse currently has 5,700 volunteers who deliver bereavement support. The charity relies upon government grants and donations to fund their services but Cruse also have considerable interest in participating in research and position themselves as being at the forefront of bereavement care and practice. This is shown in their Early Intervention Project, which was launched in 2013 and funded by the Department of Health to target people at risk of 'Prolonged Grief Disorder'. Cruse's participation in this study accounted for three interviews: one with a bereavement support worker, and two interviews with individuals involved in the Early Intervention Project.

Caris Islington Bereavement Service

Caris (Christian Action and Response in Society) is a charity that provides a bereavement service to those who live in the borough of Islington, in North London. The bereavement service was established in the early 1980s, as a deanery project by the Anglican churches in Islington, managed by the deanery 'Social Responsibility Committee'. CARIS Islington resolved to become an ecumenical project, although most of its funding relies on the support of local churches. Caris provides training for volunteer counsellors, all of whom are already undertaking or have completed other formal counselling qualifications. The service Caris provides is open-ended and maintains around 40 counsellors and approximately 180 referrals a year of which half become clients. Caris also runs a cold weather shelter as a parallel project that provides nightly accommodation to over 100 homeless people in total in participating churches. Caris carried out their own research into what they discovered were notable links between homelessness and bereavement, publishing a report in 2010 (CARIS Islington, 2010). The counsellors from Caris form the majority of the data on

bereavement care practitioners presented in Chapter 6 with six counsellors involved. This was in part due to the assistance I received from the Caris staff coordinator who approached counsellors to participate in the study in the first instance.

St Christopher's Hospice

St Christopher's Hospice was founded by Dame Cicely Saunders in 1967 and is widely regarded as the first modern hospice. It is located in Sydenham, South East London. St Christopher's is a charitable organisation that relies on donations. St Christopher's bereavement services consist of one-to-one and group support delivered by volunteers who receive training. I interviewed a bereavement support worker and bereavement service senior supervisor at St Christopher's. I also attended a bereavement support group to present my research, which led to one further participant in the study.

Grief Recovery UK

Grief Recovery UK is a not-for-profit organisation, which is the UK branch of the Grief Recovery Institute founded in the USA. The Grief Recovery Institute was born out of the Grief Recovery Handbook, which was created by John W. James who had developed his own unique strategy for recovery from loss following the death of his young son. The Handbook (James & Friedman, 2009) declares: 'It's not counselling, it's not therapy, it's not an alternative treatment'. The method is described as an 'action program for moving beyond death, divorce and other losses including health, career and faith'. It comprises a series of trademarked steps and activities that promise 'completion' and recovery from loss. Grief Recovery UK actively trains 'Grief Recovery Specialists' and support is delivered in a group or one-to-one setting. I conducted two interviews with the director of Grief Recovery UK as well as attending

its training workshop.

British Association for Counselling and Psychotherapy

Seven counsellors I interviewed were registered with The British Association for Counselling and Psychotherapy (BACP). BACP is a registered charity, formed in 1977, with the vision of providing an ethical framework for talking therapies and to provide education and training for counsellors. The BACP also accredit training courses for its members to undertake as part of their Continuing Professional Development, including the Grief Recovery UK workshop.

Tables 1 and 2 (see Appendix 5) list the names and details of each participant. In the table of professional participants I have provided each with an identifier to distinguish between those who were trained and qualified as counsellors and those trained as bereavement support workers (without prior counselling qualifications), e.g. bereavement counsellor as 'BC1'. I also spoke with current and former mental health service users about their thoughts on recovery and these three participants are described in Table 3 (also included in Appendix 6). The nine participants in Table 2, who told me about their experiences of grief, had experienced different types of bereavement and were predominately middle-aged with an average age of 50. In some cases the participants had never used any form of bereavement service. My selection of participants does not aim to be representative of bereaved people's experiences but the smaller number of male participants, three male to six female, corresponds to other studies on bereavement that suggest that men are more reluctant to participate in research.

4.3.5 Conducting the interviews

Before the interview, each participant was given full details of the research in the form of an information sheet and asked to sign a consent form (see Appendices 2, 3 and 4). The information sheet informed participants of their right to withdraw and what would happen to the findings of the project. Participants were assured in writing and in person that all research data, including participant details, interview data, and field notes and data analysis would remain confidential at all times and only be viewed by myself and discussed with my supervisors. All names and any identifying places have been changed. All data collected as part of the research was stored in a locked cabinet or on password protected computers. Storage of data, at all times, followed the guidelines set by the Data Protection Act (1998) and the Freedom of Information Act (2000).

I carried out 27 semi-structured qualitative interviews with 25 participants, across England. Each interview was recorded on a digital recorder. I also kept a fieldwork diary in which I made notes during interview where necessary and where I wrote up thoughts, ideas and reflections after each interview. These notes assisted in adjusting or adding questions for subsequent interviews. Interviews were carried out in different locations, both public and private, and included counselling rooms, cafes, or the participant's home. The participants largely divided into two groups, those participating due to their professional role in bereavement care and those who talked to me about their personal experiences of grief. I developed two interview schedules for the two 'types' of participant (see Appendix 6). I also conducted three interviews with people who had experience with the mental health system in England, particularly in relation to the recent 'recovery model' of mental health care.

For the interviews with practitioners I aimed first to find out more about their role, practice and professional background. Secondly, I sought explanations and rationale for the type of approach taken towards understanding grief and recovery. Further, I wanted to gather empirical examples of handling people with 'complicated' grief, which had emerged as a key theme in the analysis of literature and documents. The interviews with practitioners were structured around the themes of approach to grief, details of treatments and therapies used, definitions of recovery and definitions of complicated forms of grief. These areas of focus were derived from my analysis of the literature and relevant documents that revealed an inconsistency in the delivery of bereavement care services in the UK, which I expand upon in Chapters 5 and 6. Further I was guided by the recommendations of a report authored by researchers at the University of Nottingham and funded by the Department of Health (2010). The report reviewed the current literature on bereavement care services and suggested that further research into bereavement care needs to provide details such as: the approach used, the frequency, duration and intensity of the intervention, and the level of training and professional background of those involved in the delivery of bereavement support. This structure enabled me to compare bereavement support across the different organisations, and aided in finding data on the components of 'grief work', presented in Chapter 6. To gain a more detailed understanding in the interviews, I constructed hypothetical vignettes or scenarios to illustrate and contextualise the questions and to seek a clearer picture of what is done in different situations. For example I would ask a bereavement counsellor what course of action they would take with someone who was struggling to recover several years or more after bereavement.

Before the interview, I clarified the aims and objectives of the research and what

participation would involve, both via telephone or email and at the interview itself. This was part of the procedure of obtaining consent from participants. This set the tone for the interview, introducing some formality into meetings that took place in public cafes or participants' homes where, over a cup of tea, the conversation could easily become more social. The physical environment influenced the extent to which the boundaries of the interview were apparent. In the counselling room setting, for example, the interview would almost mirror a counsellor-client exchange. The interview format, regardless of setting, drew parallels with a counselling session to the extent that my input was limited and I was utilising the skills of active listening. In the counselling room therefore it was easier to facilitate this space. The 'props' such as lack of noise, comfortable seating, a visible clock, tissue box were present and so the boundaries were mostly unspoken and did not require reinforcement. Knowledge was thus assembled in interviews through the structuring of the interview questions and the responses of the participant but also in the physical setting of the interview, the time of day the interview was conducted, body language and creation of a 'rapport'. As Holstein and Gubrium (1995) identify, interviews are 'collaborative accomplishments'. The interview setting produces a 'situated' form of knowledge; a different time or place might have produced a different story and different interpretation.

The interviews in most cases lasted for one and a half to two hours. I travelled across London and around the country to conduct interviews that took place either in a room arranged through one of the participating organisations, the participant's home or a public venue. I tended to schedule no more than one interview a day to accommodate for any travelling time and to provide time to write up any notes following the interview. The order of the interviews was determined by the

availability of the participants and so I interviewed practitioners and bereaved participants concurrently. I listened to the tape recording on the same day of each interview in order to note down initial thoughts and to ensure the interview was recorded in full.

In the interviews with bereaved people I was specifically interested in what types of services or help they had received, if any, and their views on recovery. However, the interviews with the bereaved participants became less structured as I realised the interview provided a space for the participants to narrate their experiences of grief. Though I had a set of questions to be answered I began to recognise that the 'data' were not only in answers to my questions, but in how the participants narrated and made sense of their experiences. As Kehily (1995) identified, narratives are constructed differently depending on the audience. I, as the audience of the interviewee's narrative, thus had a role in how the stories were shaped and accounted for, not only in the questions I asked, but also in the expectations the participants may have had of what I wanted to hear.

The format of the interview assumes a competent, rational, consenting interviewee. However, as discussed above and in Chapter 3, within this thesis I am destabilising the notion of the intentional self-reflexive subject. Rather, my interest was to explore how people differently performed identities. Participants volunteered to participate on the basis of their expertise or their personal experience of grief. Identifying as a 'member' of a group meant participants spoke as members of that group, whether as a counsellor or a bereaved person. Arguably, interviews elicit or encourage performances of the modern subject. I address this in Chapters 8 and 9, as I began to acknowledge the limits of my chosen method to finding the 'unrecovered' person,

when one of the key components of finding recovery is through the ability to voice a coherent story.

4.3.6 The reflexive research process

In qualitative grief and bereavement research the 'situatedness' of knowledge is more pertinent when the fact of death and mortality is something 'we' are all 'inside' and part of (Woodthorpe, 2007). Oakley (1981) contends from a feminist methodological perspective that 'disengagement' from the interview encounter is not possible. Yet Rowling suggests grief and bereavement researchers should strive to be neither too 'in' nor 'out' but 'alongside' participants (Rowling, 1999). Acknowledging the situatedness of the knowledge involved being reflexive to my own biases. As outlined above, by 'unlearning my privilege' I sought to make conscious the 'impact' of my subjectivity on the interview. Being 'reflexive' does not promise objectivity, it is rather a strategy that helps to reduce harm to the participants, and being clear about one's position as researcher. This reflexivity was something that required constant renegotiation in the fieldwork process, and was integral to achieving transparency in the influences on the data.

The clarity of these boundaries was at times problematised by the emotional nature of the interviews. Empathy (however that is defined) is commonly agreed as key to establishing a 'rapport' with participants (Mauthner et al., 2002). How rapport is 'done' successfully, however, appears to rely on the competency of the researcher to communicate effectively with the participant, and to gain their trust and confidence in a short period of time. Taking a Foucauldian approach to power relations, I understood the interview setting was no more bereft of power relations than any

other encounter. It was my intention to be as vigilant as possible to the possible exploitative effects of the power relations that might form. This also involved monitoring my own emotional response to the interviews. Maintaining the stance of active listener, and seeking to build a rapport, while maintaining clear boundaries was not always straightforward. At times, it seemed that what was 'theirs' and what was 'mine' was impossible to disentangle. For example, following the interviews of some of the bereaved participants, listening to their accounts of grief and bereavement, would lead me to think about the inevitable loss of those close to me. My responses to their stories also became data. I thus saw my own body as another participant immersed in the space, as illustrated next.

During a post-interview conversation with the organiser of the Grief Recovery UK workshop I disclosed that carrying out the fieldwork was causing me to reflect on my own experience of grief. She invited me to attend the personal Grief Recovery workshop. As I was attending as a participant I did not use the responses or experiences of other attendees as data. What I did use from the workshop as data was what I learned from the workshop about the Grief Recovery Method, including the facilitation by its leader, to inform my understanding of the method. I also documented my own reflections on the workshop as data. However, I was also introduced to the group as a researcher and so I was there with a dual purpose of 'working through' my grief while learning of the techniques and methods of Grief Recovery UK that would inform my thesis. I participated in three days of activities where I fully participated as a fellow griever – despite my introduction as a grief researcher. I carried out exercises in which I had to draw up a timeline of my 'loss history'; I had to be open and speak about my losses in front of the other attendees.

I only gained access to the workshop by being 'inside', through my mention of the struggle I was having with my own feelings during the field work. But being 'inside' meant that at times it was difficult to measure my distance from my research object. The incident caused me to reflect on how to balance what I, as researcher, wanted from the participants with what they might have wanted from me. As researcher, I could be clear about what I wanted from the participants but I could not know what they might want from me and whether I was prepared to give it. For example, at the end of one interview a participant asked me whether I had a 'significant relationship'. When such a question arises it has the potential to destabilise the 'performed' researcher identity I had chosen to play. I replied honestly, not knowing what the right answer was and whether I had satisfied the curiosity of the participant.

Through this process of 'unlearning' I still had to find 'somewhere in particular' in order to find the 'larger vision' (Haraway, 1991, p. 590). Being reflexive was not only about my relationship to the field and to my understanding of grief, but about playing the role of researcher more effectively so that my participants could position themselves in relation to me. Unlearning my privilege then became about taking responsibility for my own emotions. As Haraway remarked: 'Positioning implies responsibility for our enabling practices' (1991, p. 587). The example of the Grief Recovery workshop highlights the fluid nature of the boundaries despite how many frameworks are adhered to. Whether this is a feature of qualitative research in general or qualitative research into grief and bereavement in particular it is hard to say. I would claim it is a consequence of the 'bodywork' (Seymour, 2007) involved in conducting interviews. While carrying out the interviews I was consistently aware of the 'privilege' I had in listening to these stories that without being in the position of researcher I would not have access to. There was an element of power in the role of

researcher that I had to learn to be comfortable with. As Valentine (2007) and Woodthorpe (2007) both discovered I had to appreciate my own role in the research and that I too was giving something in the interview encounter that I could only hope was of benefit in some way.

4.3.7 The analysis of the data

As described above, the data comprised documents - including policy documents, newspaper and magazine articles, and lay literature on grief and bereavement - and recorded interviews, which were transcribed verbatim. The interview data and document analysis required different modes of analysis, which I then brought together to build overall themes, a process that I will now explain.

In carrying out the document analysis I borrowed tools from an approach broadly understood as 'discourse analysis', however my method drew very much from the Foucauldian strand within this larger field (Kendall & Wickham, 1999). This involved highlighting common themes that became codes, such as metaphors that implied 'recovery as a journey'. These codes were then collapsed into categories, for example 'individual responsibility', 'hope', 'choice'. In my analysis I focused on three main areas: how ideas and people were explained and presented within the text; how the text related to other texts; and how the document was used and received. I drew on the work of Smith (2001), who has argued documents produce or reflect 'social facts' about people or phenomenon. Within my analysis I considered documents as being socially produced but which also produce social actions. For example, the theories discussed in Chapter 2 were used in practice by the bereavement care counsellors and support workers. Following Atkinson (1990), I also acknowledged these

documents were used, consumed and shared in different ways and across different social and historical contexts. The meaning of the documents lay not only in the embedded meaning but how they were received and acted upon. Precisely how a document produces action is the empirical question (Smith, 2001). For example, government policy documents concerning mental health reforms, discussed in Chapter 5, I argue spearheaded a political and economic agenda of 'happiness' and the spread of individual psychological therapies.

The comparison of different documents and literature around grief allowed me to analyse the dominance of widely held discourse about grief. The repetition of words across texts takes the idea out of the local context and into a wider discourse. Following the description of 'explanations' in Section 4.2.2, I focused on the language and 'operative concepts' used to describe grief, recovery and bereaved people. This entailed noting repetitions of words for example the repeated use of 'choice' or 'complicated grief'. A repetition of words and concepts was significant in identifying how thoughts and ideas became a discourse or knowledge. In the analysis I also acknowledged how these ideas were presented, for example the form or genre of the text. A government policy document, for example, has a standard report format in contrast to an online forum. The structure of the document allows different claims to be made about grief and may seek to persuade by drawing on strategies such as linguistic devices, making reference to other authorities such as scientific data, or using a personal narrative.

To analyse the interviews I conducted a thematic analysis by coding the content of the data. My focus was to move beyond the meanings of the interview accounts to how they connected with other discourses and interventions around grief and recovery. During analysis of the interviews I noted connecting themes that began to build up a

particular picture around grief and recovery. I read and re-read the transcripts several times noting down repetitions and recurrences to construct an initial long list of themes and ideas. I was aided by the four questions Hollway and Jefferson (2000, p. 55) suggest all researchers should consider when analysing qualitative data: What do I notice? Why do I notice what I notice? How can I interpret what I notice? How do I know if my interpretation is the 'right' one? With subsequent readings of the transcripts, the long list came to be refined to three overarching themes that were then separated into sub-themes. The themes of 'meaning', 'practices' and 'identities' I felt best captured the variety in the data and also allowed for multiple stories to be told. For example, the meanings people constructed around grief influenced how they acted and the types of practices they employed, which in turn shaped the sort of identity they adopted. The themes could be used to explain the evolving nature of identity, meaning and practices that occur in the liminal space of grief.

Delving into the stories people tell about themselves and their losses, I was constantly struck by how participants, whether practitioners – those trained in ways of speaking about grief – or those sharing personal experiences of grief, would speak about grief in metaphors. For example grief was often described as a 'dark' place and a sense of 'going downhill'. These metaphors seemed to be a way of grasping at this thing 'grief' which kept eluding concrete terms. In Chapter 1 I stated my interest in exploring the way 'recovery' is a metaphor that 'hides' and 'obscures' the understanding and experience of grief. Rosenblatt (2013) has called for bereavement researchers to focus more attentively to metaphor and how people describe grief, rather than searching for ways in which grief can be measured. Bleyen (2009) has stated that death is impossible to imagine and can only be made present through metaphors. Further, he argues, similarly to Lakoff and Johnson (1980), these metaphors are not

just linguistic devices but present in thought and practice. Specifically, Lakoff and Johnson (1980) argued that metaphor is deeply intertwined with how people think and conceptualise ideas. I analysed the metaphors people used to describe grief as an insight into the sensory and experiential aspects of grief. Further, Lakoff and Johnson describe how these metaphors exist within a cultural system. Metaphors structure and organise experience both internally and externally in the actions people make. People therefore inherit the types of metaphors they might use to describe experiences that tend to have coherence within a larger cultural system. Metaphors reflect assumed notions, such as 'grief is a journey', which emerged out of the data I collected.

One of the key metaphors I discovered in my analysis was the notion of grief and recovery as 'work'. In Chapter 2, I highlighted the dominant notion of 'grief work'; but I also uncovered that this 'work' could take different forms, as I describe in Chapter 7. Work was also a recurrent notion in policy and literature on mental health recovery. Grief was described as something that could come back to 'bite' and so needed to be fought and prevented against and this was done through individual work; a metaphor appropriate to a society that encourages people to be employed and frowns upon those out of work, as though it is a failure of individual will (detailed further in Chapters 5, 6 and 7). The way people described grief therefore had direct implications for how they acted upon it, and these descriptions did not exist in isolation but were tied to a cultural history and system of thought.

Thus the choice of metaphor may serve to highlight some aspects of experience, and hide others. During the analysis I was constantly aware of this silencing in the text. As I came to transcribe the interviews I realised how I walked away from an interview encounter carrying one impression but in the process of typing speech into words on

a blank page it impressed upon me in a different way. Often this was because how people communicated things to me was through mumbles, or gestures, or silences. In the interview I understood and interpreted them in one way but this interpretation felt lost in the transcribed text. It seemed that at each level of communication - from narrating the experience into speech, to my capacity to listen, to the recording of voices, to the transcription of voices into text, and from the text into themes and codes and thesis chapters - something was being lost, or at least did not fit the code I had established. I came to understand this 'silence' as key to capturing the experience of 'non-recovery', which I explain in Chapters 7 (Section 7.2.) and 8 (Section 8.2).

4.4 Conclusion

In this chapter I have outlined the methodological approach of the thesis. I explained how my understanding that knowledge is situated and constructed is suited to an empirical enquiry – and how that enquiry can help to make visible less dominant and absent discourses that have been overshadowed or even occluded by what Foucault would call 'régimes of truth'. I have drawn on the genealogical approach of Foucault to describe my focus on 'problematizations' of grief and recovery. In addition, I utilised the concepts of explanations, authorities and technologies as themes in my analysis. I also described Foucault's understanding of subjectivities. I argued that contrary to his critics, Foucault gives space to consider the materiality of the body from which can emerge resistances to discourse and power. However, I seek to extend Foucault's ideas on subjectivity by using empirical methods to elaborate through individual first-hand accounts the 'figures' of grief identified in document analysis.

In this chapter, I have tried to emphasise how carrying out the research was a process and how my perspective shifted and developed as I negotiated access to the field and began to analyse the data. In doing this, I acknowledged my own subjectivity in the research and the use of reflexivity in becoming aware of the power relations of the research encounter. In particular, this increased my sensitivity in the analysis of the data, focusing on the metaphors people used and how this served to highlight and obscure aspects of the experience of grief and recovery. As the research unfolded, I struggled to put a reality to the figure of the 'complicated griever' whom I had encountered in the research literature. In the following three chapters the search for the 'complicated griever' is documented alongside the discovery of the ways in which grief and recovery are framed, practiced and lived. I present the findings of the research beginning in Chapter 5 with an analysis of the cultural framing of grief that draws on the data from the document analysis. In Chapter 6 I present accounts of the professional bereavement care participants, followed in Chapter 7 by the accounts of grief by bereaved participants.

CHAPTER 5

The cultural and political framing of grief

5.1 Introduction to the chapter

In this chapter I detail some of the cultural, political and economic factors that I contend frame how the bereaved person manages their grief and potential recovery. As first described in Chapter 3, I view the experience of grief as a liminal space that people have to navigate. For example, the bereaved person negotiates various different powerful discourses from those groups and individuals with a vested interest in bereaved people recovering from grief. The ways in which someone can negotiate this space are multiple and I highlight here some of the key discourses that frame the contemporary experience of bereavement in England, and that influence how a person might make sense of their grief. The acknowledgement of the broader cultural, political and economic concerns is central to the argument of this thesis which claims that the ways in which grief and recovery are understood and practised can be linked to permutations in contemporary neoliberal governmentality; as Árnason's work has demonstrated (Árnason, 2001, 2007; Árnason & Hafsteinsson, 2003). Throughout this chapter I utilise the concept of 'governmentality', first originating in the work of Foucault and later employed in Rose's (1985, 1989) work on the 'psy' disciplines, to consider how diverse authorities, whether political, economic, medical, or from popular culture and media, seek to act upon the lives and conduct of the grieving person to achieve desirable states of health and happiness through 'régimes of truth'.

Much research has focused on the changing nature of mourning rituals in the UK and detailed the role of funerals and the disposal of bodies in aiding the bereaved person to transition into a new changed identity and reintegrate back into 'normal' society (Hockey et al., 2001; Walter, 1999). While the changing nature of rituals around grief is significant and will be the focus of the opening of this chapter, I also want to draw attention to the political and economic factors that frame how 'negative' emotions are managed and treated, as well as how recovery from mental distress has been transformed by recent developments in mental health care. In doing so, I draw on the data gathered from the variety of documents and literature that I analysed including: bereavement memoirs, novels and poetry, government policy documents and statistics, media coverage, and online websites (see Chapter 4 Section 4.3.1). The aim of this chapter is to provide a context for the subsequent focus on the data collected from interviews with practitioners and bereaved people in Chapters 6 and 7. In this contextual frame, the interview data illustrates how the dominant discourses are reaffirmed and perpetuated and also resisted and renegotiated.

First, I discuss the changing attitudes towards grief in light of the current move toward establishing psychiatric diagnostic categories of grief. I contrast the ways in which grief appears, on the one hand, to be increasingly a matter of medical concern with, on the other, the literary uses of grief, in memoirs, fiction and poetry. In particular the grief memoir provides an interesting example that blurs simple distinctions between the 'public' and 'private' expressions of grief. I suggest that while creative writing and literature potentially provide a privileged site where grief and different expressions of grief are accepted, access to this site is not available to all. Furthermore, I argue that the expression of grief through literature can be used not only as a source of consolation but as a form of 'resistance' to assumed notions of

appropriate grieving.

Second, I move into the political and economic arena to describe how the British government from the turn of the millennium has become increasingly involved in people's emotions and well-being, creating tools to measure the nation's happiness as an index alongside economic progress. What has been described as the rise of a 'happiness agenda' (Davies, 2015) has not only had a great impact on the delivery and form of psychological therapies in the NHS but also has spawned a vast industry on the cultivation and maintenance of the 'happy life'. Working in parallel with the happiness agenda is the popularisation of recovery in mental health care, notably the creation of a recovery-focused model of care, which will be the focus of the third section of this chapter. While the happiness agenda encourages all individuals to take responsibility for increasing their own happiness, the recovery model encourages those diagnosed with a mental disorder to recover from their illness. I will explain how what began as a liberating message to allow people to live with their mental distress became an obligation to recover, where recovery in mental health care has come to be defined by professionals rather than service users.

I will argue that what makes a happy life and what defines recovery are remarkably similar to the central tenets of neoliberal values with the repeated emphasis on individual choice, rational agency and responsibility. The shaping of the neoliberal subject thus sets the scene for how grief is valued and treated in contemporary UK society and demonstrates how the concept of recovery emerges to aid people away from grief and towards the happy life.

5.2 *Changing attitudes to grief and bereavement in England*

In Chapter 2, I described what had been considered a 'new wave' in bereavement research. This new wave revealed how people continued bonds with deceased people, highlighting and celebrating the diversity and individualised nature of grieving. Alongside this was the declaration of a 'revival' of death (Walter, 1994), contesting the notion of death and dying as a social taboo (Gorer, 1965; Mellor & Shilling, 1993). Walter (1994) has argued that this revival was evidenced in public displays of grief following deaths of public figures or in the aftermath of natural and human disasters⁵, as well as in the focus on individual choice and patient-centred care in the delivery of palliative and bereavement services. For Walter this revival could be separated into the modern and postmodern period. With the advent of postmodernism, he argued, death and bereavement became instances that threatened individual identity in the absence of 'traditional' rituals. This conflicted with a modern rationalism that saw medicine exert further control over death. This, Walter argued, formed a divide between 'public' and 'private' realms of grief where the public was unnecessarily encroaching on the private nature of grief.

Walter's distinction between modern and postmodern attitudes to death and grief has been problematised by Arnason and Hafsteinsson (2003) and Howarth (2000, 2007). However, this distinction between modern and traditional forms of mourning echoes a common nostalgia found in texts on grief and bereavement where the 'problem', as it is considered with grief today, is due to an eradication and absence of rituals around death that used to provide the means for navigating the liminal space

⁵ For example the public mourning over the death of Princess Diana, the 2004 Boxing day tsunami in Thailand, and the attack on the twin towers on September 11th in New York.

of grief. On the contrary, I seek to argue in this section that there is a proliferation of guidance on how to manage grief; techniques that could be described as contemporary rituals. My focus here is on two contemporary areas of concern that I contend seek to manage, make sense of and bring order to grief much like formal mortuary rites of the past. Those areas to be discussed below are: the interest in diagnosing grief as a psychiatric disorder, which many consider a medicalisation of grief, and secondly, the continued fascination with grief as a subject for literature and autobiographical accounts.

My understanding of the role of mortuary practices is indebted to Bloch and Parry's definition (1982), described in Chapter 3, where mortuary practices serve to reassert social order at death and further that social order is, itself, a product of rituals. These contemporary rituals, as I describe them, are not simply managing and organising grief but reshaping how grief is understood. Rituals around death are productive sites that act to produce particular forms of subjects, framed by the performing of certain emotions (Davies, 2011). Yet mourning rituals also seek to reintegrate the bereaved person back into society (Turner, 1969). In what follows I endeavour to explore this complex relationship between an increasingly medicalised approach to grief and one that strives to embrace and celebrate the individuality of the griever. In doing so, I hope to blur the distinction between the private and public face of grief, a theme that remains salient throughout the chapter as I consider the effects of government public interventions in individual private emotions and well-being.

5.2.1 Grief as a mental disorder

The publication of the fifth edition of *Diagnostic and Statistical Manual of Mental*

Disorders (DSM-5) (American Psychological Association, 2013) provoked a flurry of controversy in the field of grief and bereavement research and across the practice of psychiatry. As noted earlier, the DSM-5 made considerable changes that affected the treatment and diagnosis of grief as a mental disorder. The first significant change was the omission of the 'bereavement exclusion' in the diagnosis of Major Depressive Disorder (MDD) that had been included in previous editions of the DSM. This exclusion protected bereaved people from being diagnosed with MDD in the first two months of bereavement. However, the change was made to the DSM-5 following arguments that grief, just like other losses, such as becoming unemployed or getting divorced, could cause depression. Thus the removal of the exclusion potentially meant recently bereaved people could be diagnosed with depression if showing symptoms for as little as two weeks. The second significant change was the inclusion of the new diagnosis 'Persistent Complex Bereavement Disorder' (PCBD) for further consideration in the next edition of the manual.

The criticism that arose from these changes was twofold: one an objection to what was seen to be an increased 'medicalising' of grief; and second, criticism of the lack of evidence supporting the category of PCBD. The critique of medicalisation garnered wide support from the pages of *The Lancet* (2012) and the *British Medical Journal* (2013) to *Psychology Today* whose regular columnist, psychiatrist Allen Frances, was one of the DSM-5's most ardent critics and who pleaded against what he argued was a medicalising of 'normal' grief (Frances, 2012). The title of Frances' column 'Saving Normal' and his accompanying book of the same name (Frances, 2013) set the tone for numerous critiques of the DSM-5, described as '[t]he war on grief' (Stolorow, 2014). Grief was positioned as something under threat and to be protected, and psychiatric intervention as the de-humanising force intruding into the most human of

emotions. The *Lancet* (2012) editorial concluded: '[F]or those who are grieving, doctors would do better to offer time, compassion, remembrance, and empathy rather than pills' (p. 589).

However, even among those who most fervently opposed the potential for grief to be diagnosed indiscriminately as depression, the belief in complicated or pathological forms of grief was widely accepted (Wakefield, 2013a, 2013b; Wakefield & First, 2012; Walter, 2006). The dispute over the bereavement exclusion was a call to protect 'normal' grief, whereas it was agreed 'abnormal' grief was something that required intervention (Bryant, 2012). Often, Freud's distinction between mourning and melancholia was resurrected in defence of the case for a distinction between normal grief, complicated grief and depression. Controversy over the proposed diagnosis of PCBD was centred on internal disputes between two well-researched categories of abnormal grief: 'prolonged grief disorder' (PGD) proposed by Prigerson and colleagues (Boelen & Prigerson, 2012; Prigerson et al., 1996; Prigerson et al., 2009) and 'complicated grief' (CG), the category described by Shear (2010, 2012; Shear et al., 2011; Shear et al., 2013). Arguably a product of the initial criticism in the preparation stages of DSM-5, amid fears of over-medicalisation, PCBD emerged as a faulty compromise. However, 'prolonged grief disorder' as defined by Prigerson has been included in the current draft of the 11th version of the *International Classification of Diseases* (ICD-11).

I argue not enough criticism however has been directed to the inconsistencies in each diagnostic category. Boelen and Prigerson (2012) provide a comparison of the symptoms of PGD, CG and PCBD highlighting the similarities and also marked differences between diagnostic categories. The most notable difference is the length

of time a person is required to demonstrate symptoms before diagnosis. While a diagnosis of PCBD is recommended only if symptoms are present at least 12 months following bereavement, PGD has a shorter time period where symptoms must be present for six months before intervention. There are also varying opinions on how many people are affected by these disorders. From the seven to ten per cent of bereaved people claimed by Shear (2010, 2012) to 15 per cent of all bereaved people stated by Bryant (2012) who remarked 'there are over a million new cases of prolonged grief in the USA each year, representing a public health issue' (p. 10).

I discuss in detail in Chapter 6 the extent to which prolonged or complicated grief is present in bereavement care and practice in England, however, initiatives such as the 'Early Intervention Project', run by Cruse Bereavement Care and funded by the Department of Health, reveal how complicated grief is becoming a prominent focus of concern in the UK. While proponents of complicated grief argue that the growth of research into the area is merely the recognition of a disorder that already existed and experienced by bereaved individuals, there appears to be some ambiguity around why complicated grief develops in some people and not others. The ICD-11 beta draft definition defines PGD as a:

[P]ersistent and pervasive grief response characterised by longing for the deceased person or persistent preoccupation with the deceased accompanied by intense emotional pain⁶.

The grief response is defined as prolonged if it has persisted for:

⁶ ICD-11 beta draft available at:
<http://apps.who.int/classifications/icd11/browse/f/en#/http://id.who.int/icd/entity/1183832314> (Accessed 6 June 2016)

(...) an atypically long period of time following the loss (more than six months at a minimum) and clearly exceeds expected social, cultural or religious norms for the individual's culture and context.

It is the 'atypically long' time period, which most clearly demarcates complicated from normal grief, and yet as I argued in Chapter 2, whatever 'normal' grief is, is still under considerable debate. This has not prevented, it would appear, the creation of diagnostic categories that rest on the assumption of a normal course of grief.

The scientific rigour of the work on complicated grief is much flaunted⁷. I suggest, this emergence of a scientific understanding of grief in contemporary bereavement research and practice, can be viewed as a new form of mourning ritual. Seale has described how modern rationality, of which medicalisation is one example, has a religious orientation: taking the place of religion in managing procedures around death and dying, but producing guidance and meaning that is equally powerful (1998). Further, he argued that medical procedures have a ritual aspect that 'frame and box experience' and that are designed to reorient the living away from death and towards life. The classification of grief into normal and abnormal forms and the interventions carried out to enable people to recover from complicated grief can be understood, then, as a means of managing the boundaries between living and dead people that serves to contain the 'risk' the complicated griever poses (Howarth, 2000). The complicated griever embodies the liminal space between the living and the dead and so presents a danger by virtue of being matter 'out of place' (Douglas, 1966).

⁷ See The Center for Complicated Grief webpage, 'The science behind our work': <http://complicatedgrief.org/the-science-behind-our-work/> (Accessed 6 June 2016)

The way in which these medical rituals are used suggests the danger the complicated griever might pose to what are considered normal, healthy emotions and behaviours. To understand why prolonged grieving poses a risk and has become problematic for many requires a wider analysis in the realm of political, economic and societal concerns. So far I have touched upon the importance of a time limit in distinguishing complicated from normal grief, however, time-limited mourning is present in a number of mourning rituals yet it takes on new relevance when considering time limits in the treatment and recovery of mental disorders. These time limits, established in the creation of a psychiatric diagnosis of complicated or prolonged grief, might be considered as a 'technology of temporalisation' (Foucault, 1975) that serve to contain mental distress or unhappiness. As I will discuss in section 5.3, such time limits on grief take on more relevance in a climate where maintaining happiness and well-being and getting back to work is a primary marker of the good citizen. Receiving a diagnosis has direct practical implications for the person's social status and standing. A diagnosis can help people to access health care; it can legitimise contested conditions and provide coherence and a narrative to its sufferers.

Brown (1995) suggests there is a need to ask of diagnosis: why is it that conditions get identified at certain times? And why is action taken - for whose benefit and at what cost? As Hacking (1986, 1999) has argued, psychiatric diagnosis is not merely the recognition of an illness already present but one that is socially produced. Mental illness and disorder are made 'visible' in the individual body through the clinician's 'gaze', which uses labels and diagnostic categories, and other tools of psychiatry. These tools, that emerged with the birth of modern medical practice as Foucault (1973) and Rose (1985) have described, sought to localise illness in the body, or more specifically in this case, in the mind or brain. As I describe further in Sections

5.3 and 5.4, the locating of illness inside the mind meant the cause and management of mental disorder became largely a responsibility of the individual. Making sense of grief, and managing the bereaved person, therefore involves medical, rational and instrumental explanations and practices as well as symbolic ones, which I describe next.

5.2.2 A private vocabulary for grief

In this section I seek to juxtapose the modern rationality of medicalisation with the burgeoning creative use of grief in literature, a mode of making sense of grief that embraces a sentiment more reminiscent of the Romantic period. Hockey et al. (2001) have documented the influence of romantic ideology on mourning practices, where responses to death were increasingly understood through an emotional paradigm. If the modern 'rationalisation' of grief which has given rise to psychiatric classifications can be understood as a product of enlightenment thought, the popularity of the grief memoir might be viewed as a continuation of the romantic individual and emotional expression through literature.

In 2015, several of the most prestigious book awards were won by autobiographical accounts of grief and bereavement. *The Iceberg* written by Coutts (2014) who won the 2015 Wellcome book prize and MacDonald (2014) who won both the 2015 Samuel Johnson prize and the Costa book award for *H is for Hawk*, received critical acclaim for their depictions of grief and loss of a husband and father respectively. The success of these titles evidences the continuing popularity of grief as a theme for literature. These titles are not anomalies; the bereavement memoir remains a consistent bestseller. Lewis's (1961) *A Grief Observed*, first published in 1961 was

recently republished as a new edition, and has been adapted for film and theatre. Other popular titles include Didion's (2006) *The Year of Magical Thinking*, Wild (2012) by Strayed (and accompanying film), Oates' (2011) *A Widow's Story* and *The Long Goodbye* by O'Rourke (2011). As well as fictional work like the recent *Grief is the Thing with Feathers* (Porter, 2015), the post 9/11 grief of *Extremely Loud and Incredibly Close* (Foer, 2005) and classic depictions of grief in Shakespeare's *Hamlet* and Bronte's *Wuthering Heights*, and even the place of grief in the *Harry Potter* series. Not to mention the great canon of elegiac poetry which serves to provide consolation from grief through its accurate expression of the emotions.

Why might people be drawn to writing about grief? In her memoir describing the death of her mother, O'Rourke (2011) wrote her 'pervasive loneliness' was the result of 'the privatisation of grief'. To write about the experience of grief is to both to find a way to express the 'unsayable' of death (Watkin, 2004) and to make public what is felt to be private. The popularity of such written accounts of grief then arguably fills the gap left between the modern divide of life and death, a gap that the authors such as O'Rourke (2011) feel are not quite fulfilled by professional grief literature. When the understanding that grief is a 'taboo' persists, then writing openly about an experience like bereavement enables people to connect to otherwise hidden and silenced stories: they offer guidelines to recovery.

Dennis (2008) in his analysis of contemporary bereavement memoirs described how grief accounts become 'vehicles of information and instruction for fellow citizens in the community of grieving' (p. 802). The autobiographical account thus acts to provide a map for others in their navigation through the liminal space of grief, arguably offering some form of consolation in learning that someone else has also

endured a similar sense of pain. Dennis outlines six narrative dimensions of the grief memoir: restitution (trying to fix things), evaluative (positive reappraisal), interpretive (making sense of it), affirmation (of deceased, of continued relationship), affective (emotional disclosure), and transformation. The well-established narrative outline provides a ready format for the reader to enable them to make sense of their loss.

Grievors also turn to language, metaphor, and the imagination to find expression for their emotions. Metaphors are often utilised in writing about grief, for example Porter (2015) in his short novel *Grief is the Thing with Feathers* conjures the image of the Crow, famously the talisman of choice for the poet Ted Hughes. In his story of a bereaved partner and father and his two young sons Porter draws on the idea of the crow as 'stronger than death' and the echoes of Hughes featuring 'Crow' who becomes the healing force in the story. A bird also plays the healer, in this case a literal bird, in McDonald's memoir of grief in which she decides to train a Goshawk. In explaining her actions she remarked: 'You can't tame grief, but you can tame hawks' (Willoughby, 2015). In both books the birds, whether fictional or real, become symbolic of the grief which they cannot express but also provide a model of being: 'The hawk was everything I wanted to be: solitary, self-possessed, free from grief, and numb to the hurts of human life' (Macdonald, 2014, p. 85).

In the grief memoir the author and their feelings are made prominent, and so rather than a 'death' of the author (Barthes, 1967)⁸, the biographical details of the author are especially relevant. The grief memoir plays a cathartic role for its author. The drive to write about one's grief is not always made explicit, more often it is assumed that

⁸ However, Barthes himself wrote at length about his feelings of grief following his mother's death, see Barthes' 'Mourning Diary' (Barthes, 2011).

writing and claiming one's narrative is automatically healing, as I discussed in Chapter 1. Finding the words to tell one's story has a central role in the politics of, and recovery from, trauma. Grief is widely believed to be an event that disrupts an individual's 'self-narrative' (Neimeyer, 2005). This is a belief that rests on a further assumption: that each individual possesses his or her own 'narrative-identity'. Creating a story about illness or grief remedies the disruption of personal self-identity caused by traumatic experiences. Coutts described the process of producing *The Iceberg* as one of 'writing against annihilation' (Law, 2014).

What has been described as a 'narrative turn' in the social sciences sought to acknowledge how telling stories is 'universal' and that human beings understand and make sense of their lives in narrative (Bury, 2001; Clandinin & Connelly, 2000; Frank, 2010; Squire, 2005). Gilbert (2002) states that humans are 'naturally orientated' to storytelling and use narrative and stories to organise, bring order and structure experience. Constructing narratives is considered to be a 'characteristically human' process; the 'narrative parsing and organisation of experience are rooted in our biology', claim Neimeyer et al. (2014, pp. 487-89). The healing properties of narrative have been especially highlighted in studies of illness, and increasingly in grief and bereavement, where constructing a narrative is seen to repair disrupted identities and enable people to reconstruct their biographies (Bury, 2001; Frank, 2006). The emerging field of 'narrative medicine' (Charon, 2006) has embraced the importance of narrative to understanding illness, placing emphasis on listening to the story of the patient as a means of producing a more humane and ethical medical practice.

Within the excitement about narratives there is a tendency to overstate the power of narration. Frank (2010), for example, enthusiastically describes the 'exceptional'

nature of narratives, listing the functions of narrative: narratives connect people and enable membership of social groups; narrative is the means through which humans learn who they are and learn between good and bad actions. For 'without stories, there would be no sense of action as ethical' (Frank, 2010, p. 665). Neimeyer et al. (2014) make a further leap inferring from a rather preliminary study using fMRI scans on people who had been bereaved (O'Connor, 2012) to suggest that: '[t]he human penchant for "storying" events, to organise temporal experience in terms of plot structures with meaningful beginnings, middles, and ends, appears to be anchored in brain structures' (Neimeyer et al., 2014, p. 487). Similar claims exist in support of the healing act of writing, where 'unresolved' trauma can 'easily spill over by way of these peptides into our emotions and into the very way our immune system interacts with disease' (Watts, 2011, p. 8).

However, in his essay on oral and written storytelling, Goody (2006) demonstrated how narrative is not a predominant characteristic of adult intercourse in purely oral (non-literate) cultures. Contrary to beliefs that narrative is a universal form of expression, Goody argued narrative is less a universal human trait and more something promoted by literacy and the advent of printing, which introduced the fictional novel as a narrative form. In his essay 'The blob', detailed in Chapter 3, Bloch (2011) described a narrative level to the blob. This narrative level is not an inherent mode of cognition as some psychologists might claim, but a form of learnt expression. Tilly argued that westerners (1999) acquired standard story packaging, causing individuals to organise experience in standard story form. He described a standard story structure as composed of a limited number of interacting, independent and self-motivated characters that make deliberate actions and possess specific motives, with the story located in time and place. Tilly and Goody both point out life histories do not

just emerge automatically but are heavily constructed by the culture in which they are situated. The proliferation of narratives of grief is not merely the freeing of the truth about grief but the production of particular types of stories about grief. Moreover, it naturalises a type of self that demands personal and emotional expression.

The resistance of a standard story structure is also, then, a resistance to an easily classifiable identity. Ramazani (1994) has described how modern forms of elegy diverge from the late romantic tradition of death poetry as one of self-definition to an 'unmasking' of the poet. The modern elegist attacks the dead or themselves and refuses orthodox consolation in God or rebirth. Modern elegies tend not to achieve but to resist consolation, not to heal but to reopen wounds of loss. This melancholic form of elegy provides no answers or solace but is purposely resistant and recalcitrant. For example, Ramazani drew on a variety of poets including Seamus Heaney and Wilfred Owen who both refused to see any consolation in the deaths in the many victims of war, or indeed place faith in the recuperative effect of poetry. For Ramazani modern elegies are 'a compromise-formation in response to the privatisation of grief' (1994, p.15-16). However it would seem that in the act of refusing consolation, the modern elegy provides a different form of 'refuge from the social denial of grief'. The popularity of grief memoirs could be seen in a similar fashion in that even if written in the act of refusing recovery the act of writing provides its own refuge from the 'impact of the thing' itself, as Lewis (1961) described it. And yet for writers or poets to find consolation in the act of writing is hardly surprising. The question remains as to how accessible such a vocabulary is and what ways people might use such vocabularies to make sense of their grief.

I return to thinking about the different types of stories a person might tell about their grief in Chapter 7. In this first section I have sought to highlight what I argue are two dominant discourses of grief that frame a person's experience of grief. These two discourses both strive to make sense of grief utilising quite different types of techniques. Science and literature within modern society are divided along the lines of the public and the private and the two realms have served to reflect a divided face of grief. However, while science utilises psychiatric manuals and literature uses metaphor, I suggest that neither one should be seen to be filling a gap left by the other. Rather they both produce explanations about the same thing: grief. In the what follows I will write more explicitly about the political and economic framing of grief, yet while the acts of government and psychologists appear to have more consequential effects, in literature and the arts grief is prized with a special human value.

5.3 *A happiness agenda*

In late 2010 UK Prime Minister David Cameron announced that the coalition government was to begin measuring the nation's happiness (Cabinet Office, 2010). The Office for National Statistics (ONS) was directed to introduce a set number of questions in their Household Survey that sought to gauge the happiness levels of the population. The establishment of a 'happiness index' emerged out of a series of events both in the UK and internationally; the central one being the revelation that more money and increased gross domestic product (GDP) did not make people happier. What became known as the 'Easterlin paradox' derived from a number of studies by Easterlin (2009), which revealed that in developed countries after reaching a certain

level of wealth, happiness and well-being plateaued. The identification of an inverse relationship between money and happiness led economists and politicians to seek out new measures of progress alongside GDP. Cameron's announcement marked the beginning of the peak of political and economic interest in happiness and well-being. It also tapped into what had become an established sub-field of psychology that focused on the fostering of positive emotions. The new field of positive psychology, stemming from the former chair of the American Psychological Association Seligman's (2002) seminal text *Authentic Happiness* provoked a wave of interest in happiness, an emotion Seligman claimed had been historically neglected in psychology with the discipline's over-emphasis on the melancholy.

Positive psychologists had some impressive claims to make from their research. Lord Layard, Labour life peer who became known as the UK's 'happiness tsar' following his key text *Happiness: Lessons from a new science* (Layard, 2011a), extolled some of the virtues of positive psychology:

The exercises positive psychology offers include the systematic practice of kindness, gratitude to others, counting your blessings, and exploiting your strengths rather than attacking your weaknesses. It also teaches resilience and optimism. These two characteristics are apparently better predictors of a person's educational achievement than their IQ. And they can reduce your annual chance of dying by 20%. (Layard, 2011b, [online])

Studies into happiness, often described as 'subjective well-being', relied upon self-report studies that asked people to measure their level of satisfaction with their life on a scale such as Diener's (1994) 'The satisfaction with life scale'. More recently,

other methods have been employed such as using mobile phone apps to alert people to measure their mood at different points during the day (Heathcote, 2011; Kahneman, 2011). The goal of positive psychology was not only to stop people being ill, but help them 'be well' by building the 'enabling' conditions of life. As Seligman (2002) described, it was about getting people from zero to 'plus five'. In his next book Seligman decided 'flourishing' was a better term than happiness confessing that the word happiness was 'scientifically unwieldy'. Flourishing had a rather broader remit in that even depressed people can flourish: 'I think you can be depressed and flourish, I think you can have cancer and flourish, I think you can be divorced and flourish' (Seligman, 2011).

While some thought the plans for a happiness index 'woolly' and 'impractical' (Duncan, 2008; The Midlands Psychology Group, 2007), Cameron's announcement was met with considerable support. The organisation 'Action for Happiness' founded by Layard, Geoff Mulgan (formerly Director of Policy in Blair's Labour government) and Anthony Seldon (the historian known for his biographies of British prime ministers) was re-launched with the goal to make a happier society. Meanwhile, the New Economics Foundation (NEF) created well-being as one of its key themes, formulating a Happy Planet Index (HPI) which aimed to show where the happiest and healthiest place is to live, and instructing people of the 'five ways to well-being'⁹. The media interest in Cameron's announcement sparked what Davies (2015) has described as a 'happiness industry'. From the BBC's 'Happiness Challenge', to laughter coaches and happiness phone apps, happiness was at its peak. Nor was the happiness trend merely 'woolly' and benign. Happiness skills were being introduced into

⁹ NEF's five ways to well-being: connect with people; be active; take notice of your surroundings and savour your activities; keep learning; give – volunteer or do something for other people.

schools and positive psychology tools, led by Seligman, were being used in the US military to increase levels of resilience.

In this section I map out how the emotional well-being of the population became a concern for economists and politicians. The political and economic agendas within the happiness agenda were, I suggest, hidden within a discourse that revitalised an Aristotelian view that happiness is what all people desire. Happiness and the pursuit of the 'good life' have long been the concern of philosophers, but in the new discourse of happiness, or what Ahmed (2010) referred to as a 'happiness turn', the economic and political incentives are all too present; for example, the 'New Labour'-inspired Action for Happiness. Within the happiness agenda, happiness is an object, both individual and collective which all are encouraged to obtain. In Ahmed's exploration of happiness, she examined the individuals who historically have been 'banished' from happiness. The history of happiness is not one of inclusivity; the criteria for happiness has discounted certain individual and groups, and affected how 'negative' emotions are socially perceived and acted upon. I argue, the move towards classifying complicated forms of grief can be considered as part of this broader political and economic imperative to alleviate the 'burden' of mental disorder and create happier more productive citizens.

5.3.1 No health without mental health

Following the Second World War and the emergence of the NHS and welfare state, government intervention into public health in the UK was expected and largely welcomed. However, the rise of policy focused on modifying individual health behaviour is arguably a fairly recent phenomenon. The second half of the twentieth

century witnessed a trend away from disease prevention being at the level of public health, shifting to an emphasis on individual responsibility. This trend was captured in policy such as the White Paper *Choosing Health: Making Healthy Choices Easier*, published in 2004 by Blair's Labour government, which set the tone for policy decisions that followed with its emphasis on individual choice and responsibility over one's well-being. This was also demonstrated later in Cameron's 'Big Society', the ethos of which was giving people more control over their lives, in the belief that when people are made to feel as if they are the 'authors of their own destiny' their sense of self-worth and well-being increases. In a similar vein Layard remarked: 'Any happy society is one in which people feel in control of their own lives' (Layard, 2011a).

As a result, government began to fix their gaze on the mental health of the nation. In *No Health Without Mental Health* (Department of Health, 2011) the coalition government set forth an improved policy to tackle mental illness. While the principles underpinning the report were individual 'freedom', 'fairness' and 'responsibility', there was also a great deal of focus on the economic impact of mental illness. Commonly described as the 'burden' of mental health (Department of Health, 2011a; Wittchen et al., 2011), the report claimed that the cost of poor mental health in 2011 was £105 billion, accounting for 23 per cent of the total illness burden in the UK. The same figures were featured in a government commissioned report published in February 2016 by the NHS England independent mental health task force (chaired by the MIND charity CEO), which proposed a five forward plan for mental health care (The Mental Health Taskforce, 2016). The report coincided with the Prime Minister's announcement of an almost billion pound investment in mental health care, adding to the estimated 34 billion pounds spent on mental health each year (Department of Health, 2016).

Wittchen et al. (2011), in their review of statistics across the European Union (EU) countries, concluded that one third of the EU population suffers from mental disorders: a finding that revealed a much greater burden of disease than previously considered. Disorders of the brain, they state, are the core global health challenge of the 21st century. *No Health Without Mental Health* was preceded by a number of other government directed reports such as the *Foresight Report* (2008) that focused on ways to create 'positive mental capital'. The report described the 'important societal value' of positive mental health:

(I)ncluding overall productivity. It is an important resource for individuals, families, communities and nations, contributing to human, social and economic capital. (Jenkins et al., 2008, p. 15)

The ways in which 'positive' mental health and mental disorders were positioned is clear: mental illness is a costly burden, and well-being is productive, most crucially in economic terms. The way to remedy the burden called for the introduction of accessible psychological therapies. Layard's report, entitled *The Depression Report* (The Centre for Economic Performance's Mental Health Policy Group, 2006), provided an in-depth proposal of a psychological service that would reduce the costs of absenteeism and incapacity benefits caused by mental ill health by aiding people to recover more quickly and return to work. The Improving Access to Psychological Therapies service (IAPT) was thus born, with the 2011 government mental health policy including many of Layard's proposals. The IAPT service was set up to provide nationwide access to evidence-based therapies in accordance with the National Institute for Clinical Excellence (NICE) guidelines, including therapies of different 'intensity' levels. The therapy of choice in IAPT was cognitive behavioural therapy

(CBT) approved by NICE for its evidence-based success rate, and favoured for its brief treatment time. IAPT was thus targeted largely at mild depressive and anxiety disorders where the delivery was lightweight with a maximum of six sessions of CBT and, in some instances, merely referral to other services or provision of leaflets. This included people being referred to bereavement services following an initial contact with IAPT, as several of the bereavement counsellors I interviewed remarked.

Addressing mental health in 2011 was particularly poignant in what might be considered the lowest point in the economic recession. In the supplementary document to *No Health Without Mental Health* which focused on the introduction of talking therapies, Burstow, then Minister of State for Care Services, made explicit this connection when he wrote: 'Following the recession, it is clear we need to heal emotional wounds, which means we are looking for a psychological recovery outside our economic recovery' (Department of Health, 2011b, p. 2). The therapy IAPT provided was seen to benefit not only the individual 'but also the nation by helping people come off sick pay and benefits and stay in or return to work' (p. 5). Ehrenreich (2010) in her book *Smile or Die*, attacked the 'Pollyannaism' of the happiness agenda, arguing it was the delusion of positive thinking that caused the financial crash to occur in the first place. Halting economic progress was not in question, even if it had been the cause of misery for many. The answer to the economic recovery was not a restructuring of the type of neoliberal economics that arguably created the problem but a psychological recovery of the citizens bearing the brunt of its aftermath.

It was not only those considered to be mentally ill who required assistance. The research into happiness had revealed that even when presented with accurate information people did not always make the 'right' choices about their health. In

order to address these 'toxic biases' a government policy unit called the 'Behavioural Insights Team' (BIT), was formed. The BIT was quickly dubbed the 'nudge unit' referencing Thaler and Sunstein's (2009) book *Nudge* that put forward the idea that people would make better choices for themselves if only their behaviour was 'nudged' the right way. While standard economic analysis had been based on the assumption that humans are rational and behave in their own self-interest, behavioural economics rested on the belief that people repeatedly make mistakes about what brings them well-being (Cromby & Willis, 2013).

The happiness agenda and behavioural economics appeared to be utilising different types of subjectivities: one that is resilient, self-motivated and in control of their well-being, and one that is simultaneously at the whim of unconscious drives and government nudges. Dolan, who was involved with the creation of the BIT, at his inaugural lecture given to the London School of Economics (Dolan, 2011), described further why it was that people made the wrong choices about well-being. In doing so he presented an almost Freudian vision of the subject, one overrun by involuntary, unconscious responses. The choices people make he argued were made unconsciously, after which people created a rationale for their behaviour. It is the subconscious reasoning that is the 'real' choice he claimed, and the thing the BIT strived to capture and manipulate.

The techniques of the BIT have received criticism raising the question over how much the government should intervene in the lives of its citizens in the name of public health. More recently it was revealed the BIT implemented a policy encouraging benefit claimants to complete an online personality test by threatening to cut their benefits (Cromby & Willis, 2013). Freidl and Stearns (2015) have also written about

the use of 'positive affect' and positive psychology as a means of coercing people into unpaid workfare programmes. In these examples a link between individual personality traits and economic productivity was clearly being enforced.

The IAPT programme in similar ways has been blamed for its simplistic understanding of mental disorder, with critics contending that the IAPT model ignores questions about how mental distress occurs (Cromby et al., 2008; Cromby & Willis, 2013). This is despite the findings by Marmot and Wilkinson (2006) who demonstrated that social inequality is the biggest determinant of individual health and well-being. In line with the positive psychology insights that assisted its creation, IAPT construes mental distress and unhappiness as a psychological defect from which people can recover once in receipt of the appropriate psychological therapy. Binkley (2011) has critiqued what he described as positive psychology's 'strikingly truncated view of the human psyche' where the emphasis is on a cognitivist approach and conscious thought processes, and where thoughts can be manipulated by sheer acts of will to alter emotional states.

Binkley and those who have provided thorough critiques of the IAPT programme (Binnie, 2015; Cromby et al., 2008) have linked these developments with dominant neoliberal policies in western countries such as the UK. A neoliberal governmentality, argue Cromby and Willis (2013), positions citizens primarily as entrepreneurs and consumers, emphasising choice, responsibility, self-determination, moral autonomy, adaptiveness and flexibility (pp. 242-3). A neoliberal type of governance thus produces forms of subjectivity amenable to such an environment. People's emotional lives are rethought along the lines of economising principles, 'valued in terms of costs, benefits and enterprises, and made subject to a distinct set of economizing

techniques' (Binkley, 2011, p. 373). Happiness becomes a regimen, argues Binkley, and what Foucault would describe as a régime of truth. Cultivating the happy life is a 'project' undertaken in the 'intimate space of everyday life' (Binkley, 2011).

The discourse of well-being has become securely established in health care policy and practice and the institutions the happiness agenda set in motion such as the ONS happiness index and IAPT continue to develop. Yet following the flurry of media coverage, publications and research into happiness around 2010-11, it would seem happiness has somewhat faded from view. In its wake has emerged a trend on 'mindfulness' meditation. 'Mindfulness' is a term used to describe a form of meditation derived from Buddhist practices. Its popularity in western societies has often been attributed to the writings of Jon Kabat-Zinn who has written a plethora of books on the topic, most notably the bestseller *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life* (1994). In brief, mindfulness has come to be understood as way of thinking that focuses on the present without judgment. This is delivered in a variety of forms, whether through self-help and adult colouring books, gardening or phone apps that alert people to have a 'mindful moment' throughout the day. The benefits of mindfulness it would appear are numerous: it reduces stress, makes people happier and more compassionate, and is as effective as medication at curing depression. Curiously, mindfulness has been eagerly adapted to the business world as well as politics, where everyone from Wall Street to Westminster are commending the wonders of mindfulness (Goldberg, 2015; The Economist, 2013; The Mindful Initiative, 2014).

In this section, I have detailed the contemporary political and economic investment in happiness and positive emotions. The ability to measure happiness provided the tools

to define happiness in objective terms, but as a consequence of the discovery of the 'Easterlin paradox' happiness has been defined not as something dependent on the structures of society but on individual thoughts and feelings. Happiness has thus come to be framed as something within the individual's reach, if only he or she could learn to make the right choices about their health and well-being. Mol has described how this contemporary 'logic of choice' within health care services in western societies promises a level of mastery over one's life but hides what it costs to reshape the world in a way that 'situations of choice' are created (2008). Along the same lines Borgstrom (2015; Borgstrom & Walter, 2015) has illustrated the limits of the choice agenda within end-of-life care where choices over a 'good death' are not always possible.

From how it is thus defined, happiness is perceived as a neutral term, flexible to the subjective views of the individual, yet Ahmed (2010) identified how the idea of happiness that has evolved is a limited and restrictive one, specifically critiquing the way in which the rise and emphasis on happiness is at the exclusion of certain individuals, groups and ideas. Happiness is a form of deferred promise; happiness is directed towards certain 'objects' that people then strive to attain such as those proclaimed to bring happiness by positive psychology like being in work, getting married, or spending time in nature. When happiness and positive emotions are viewed as the endpoint of all endeavours, unhappiness registers as something that gets in the way. Ahmed, instead, posed the argument that unhappiness should be treated as more than something to overcome. Yet, as I will go on to discuss, recovery from unhappiness and mental distress is precisely the goal that individuals, governments and health care services are orientating themselves towards.

5.4 *The journey to recovery*

Alongside the proliferation of government policy, psychological research and public interest in happiness and well-being, was the popularising of a 'recovery model' in mental health care. It is not an understatement to note that recovery is one of the most significant transformations in mental health care policy in recent times. NHS mental health services now declare themselves as 'recovery-orientated' or 'recovery focussed'; 'recovery colleges' have been set up around the UK, now numbering 26, and recovery is a central focus in psychiatric research (Roberts & Wolfson, 2004; Slade et al., 2014; Slade, Adams, & O'Hagan, 2012; Summerfield, 2002). In this section I shed light on what recovery means for mental health care policy and suggest why recovery has captured the imagination of policy makers and service users alike. I draw on data gathered from policy and literature as well as three interviews conducted with current and former mental health service users to present the different perspectives on the meaning of mental health recovery. Establishing what recovery means is no straightforward task and most policy, articles or books on the topic will begin with the preface that no one definition of recovery exists. This is in part an intentional consequence as mental health service users and survivors first embraced the term recovery as a way to describe ways of living fulfilling and meaningful lives with their mental illness. Oft-cited definitions of recovery include that of Anthony (1993), who described recovery thus:

[Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness.

Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself. (1993, p. 11)

Further, another popular definition provided by Deegan (1996) who, in her book *Recovery as a Journey of the Heart*, described the goal of the recovery process:

(...) is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. (1996, p. 92)

Policy and research papers such as *No Health Without Mental Health* detailed above frequently cite these two definitions. In these definitions of recovery the unique and self-defined nature of recovery is emphasised. This reflects the radical beginnings of the recovery movement made possible by the anti-psychiatry of the 1970s and the rise of a psychiatric survivors' radical movement that demanded change to the paternalistic and often oppressive mental health care of the past. The contemporary model of recovery, however, has also incorporated the consumer movement in health care as well as the applying the insights of positive psychology where choice, hope and responsibility are terms commonly found in descriptions of recovery.

Recovery thus began as a liberatory message of resistance against the medical model of understanding mental illness and what were considered the normative goals of psychiatric care; yet has since permeated mainstream mental health services. The official introduction of recovery into NHS mental health services was heralded with the New Labour government's 'vision' for mental health care in 2001 entitled *The Journey to Recovery* (Department of Health, 2001). In this document the government

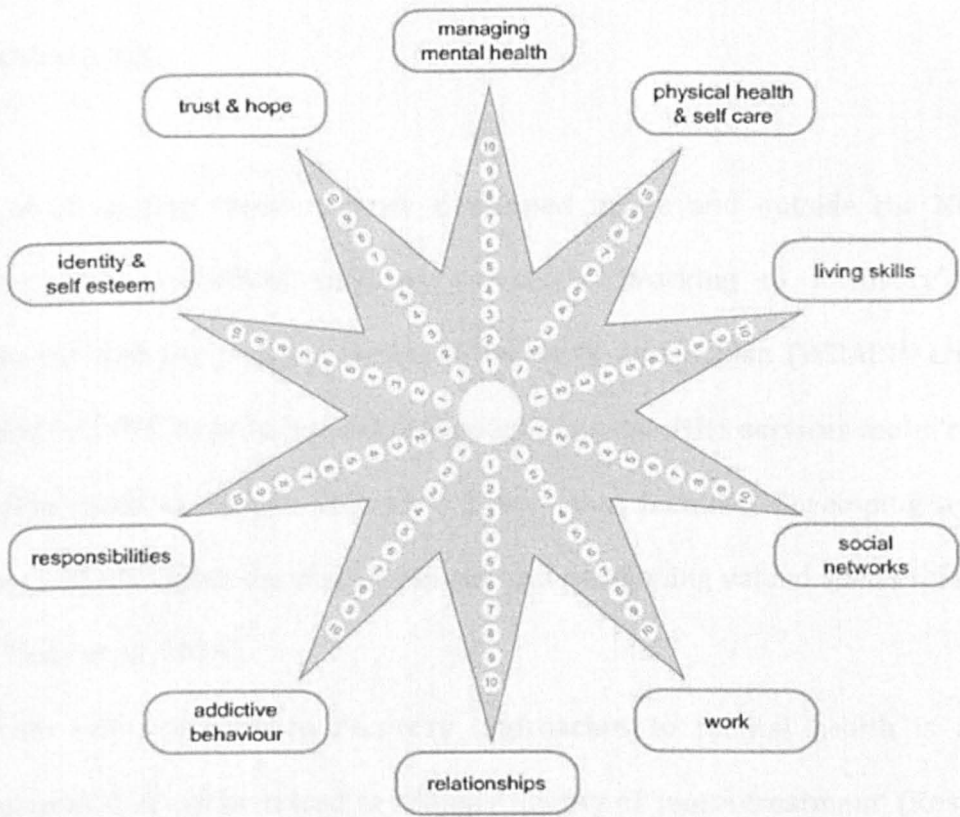
laid out their plans for modernising the 'defective' and 'chaotic' mental health care services of the past, where it was claimed people with mental illness were not expected to recover. In the 'services of the future' recovery will be spoken about as much as illness, after all 'the vast majority have real prospects of recovery' (Department of Health, 2001, p. 24). In this vision, the government employed the use of 'we', a 'we' that appears to apply to different groups at different times, whether the government, the mental health staff or the service users, for example: 'We will then be involved in agreeing a care plan, which identifies our needs...what we think our recovery goals should be' (p. 14). Later the 'we' seemed to refer to staff: 'We need to create an optimistic, positive approach to all people who use mental health services' (p. 24). The confusion of the author of the document over who 'we' was and what 'our' needs were presented a bigger effect of the encroachment of recovery discourse in policy, where mental health service users were beginning to be seen as humans with choices and a voice, blurring the division between mentally ill and well people. This theme was illustrated in the emphasis on enabling and empowering citizenship as closely tied to recovery, acknowledging a need to aid service users into engaging with 'ordinary social activities' and finding a 'meaningful occupation' (p. 25).

In one respect, the New Labour vision could be considered a noble one, wanting to 'foster the understanding that mental illness is no more to be frowned at than breaking a leg' (p. 25). Yet the 'mainstreaming of recovery' (Rose, 2014) was not without its problems. First, recovery was defined in two ways: clinical and personal recovery. This distinction, argue Harper and Speed (2012, p. 13) 'functions to effectively locate "personal recovery" as an adjunct to clinical recovery, and this complementarity avoids recovery being seen as inherently contested'. This somewhat distorted the definitions of those like Anthony and Deegan, which policy makers and

NHS services were themselves referencing. Recovery was then provided with outcomes, such as the 'recovery star' rather than being a unique self-defined exercise. The 'recovery star' included the following dimensions:

Figure 1 The recovery star

(Copyright: Triangle Consulting Social Enterprise Limited and the Mental Health Providers Forum (MHPF))



The parameters of recovery were evolving in a similar vein to the goals of positive psychology. This was no coincidence due to the influence of happiness research on the recovery model (Slade, 2010). By 2010 recovery had been well-established in mental health care policy as demonstrated by *No Health without Mental Health*, where one of its six main objectives was that 'more people with mental health problems will recover' (Department of Health, 2011a). As described above, this was the

comprehensive mental health strategy put forward by the coalition government. Recovery appeared under one of the three values proposed 'freedom, fairness and responsibility' (Department of Health, 2011a, p. 16). 'Freedom' in this regard involved having:

[A] good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose (...) improved chances in education, better employment rates and a suitable and stable place to live. (2011a, p. 82)

Ways of measuring recovery were developed inside and outside the NHS from survivor-driven initiatives such as Coleman's 'Working to Recovery' training workshops¹⁰ and the popular Wellness Recovery Action Plan (WRAP)¹¹ created by Copeland in 1997; to programmes that sought to make NHS services more 'recovery-orientated' such as Slade's 'Recovery Tasks', that included developing a positive identity; self-managing the mental illness; and developing valued social roles (Slade, 2009; Slade et al., 2014).

The state intervention into recovery approaches to mental health is a recent development that can be traced to a longer history of 'moral treatment' (Rose, 1985). Many accounts of the recovery model highlight the description of the York Retreat written by Tuke in 1813 as a turning point towards the humane treatment of mental disorder away from the Victorian asylums, now written about with much disdain as 'overcrowded', 'awful' and 'appalling' places (Department of Health, 2001). More significant, perhaps, was the development of thinking about the causes of mental

¹⁰ The Working to Recovery website: <http://www.workingtorecovery.co.uk/home.aspx> (Accessed 6 June 2016)

¹¹ The WRAP website: <http://mentalhealthrecovery.com/> (Accessed 6 June 2016)

illness that allowed for the changes in the provision for and care of people with mental distress, as I describe next.

5.4.1 A culture of trauma

Rose (1985) has documented the rise of psychology as a discipline and how it became incorporated from the fringes of experimental pseudo-science to a domain of knowledge that increasingly came to influence and govern different populations from the military to children and families. The First and Second World Wars are thought to have provided the catalyst for this change over the twentieth century in the shifting perceptions of the cause and treatment of mental disorders. The emergence of the shell-shocked soldier has become a poignant figure that motioned this shift from understanding the causes of mental distress as moral and hereditary to a physical phenomenon (Leese, 2002; Shepard, 2002). Shell shock was remarkable in its indiscriminate reach, presenting as a cluster of symptoms previously viewed as specific to female hysteria (Appignanesi, 2008; Leys, 1994). The sheer quantity of cases of this non-physical injury of war posed an interesting problem to the medical profession, which arguably paved the way for the first wide-scale intervention into the mental health of the population.

The treatment of shell shock was a key instance of mental illness becoming a matter of 'social hygiene' (Rose, 1989). The occurrence of mental disturbance produced from the experience of war rather than an internal trauma based in family history, stimulated the experimentation with new behavioural therapies at places such as the Maudsley hospital (Marks, 2012) that dispensed with Freudian heavy psychoanalytical approaches. With a strong need to get soldiers fit enough to return to the front line, behavioural therapies emerged amid an interest in treating the

symptoms instead of the mind, an approach that had a more materialistic understanding of mental distress. During and following the First World War, society witnessed the creation of specialist hospitals such as those at Maghull, the Maudsley, and Craiglockhart (Jones & Wessley, 2005). Other notable developments included the opening of 'recovery homes' by the Ministry of Pensions and the formation of a national network of psychotherapy clinics in 1919-20 (Leese, 2002). Many of the doctors who treated shell shock during the war spread across the UK afterwards, so the new ideas in psychiatry spread.

It also cemented a new relationship between psychology and the military, where recruits had to undergo psychological screening (Jones & Wessley, 2005; Shepard, 2002). As Shepard (2002) has documented, this was rediscovered during the Vietnam War, giving rise to the establishment of Post-Traumatic Stress Disorder (PTSD) as a psychiatric disorder in the DSM III in 1980. For Shepard, from this 'rediscovery' of trauma emerged a whole 'culture of trauma' that saw debriefing by counsellors after traumatic events as common practice (Seeley, 2015) and a rising interest in real-life trauma stories as a form of media entertainment.

I argue this culture of trauma also set the appropriate environment for notions of psychological recovery that proliferate today. As Glyde (2014) put it, this 'recovery industrial complex' is embodied in the powerful ethos of Alcoholics Anonymous (AA) established by recovering alcoholic Bill Wilson in 1935 originally with an evangelical Christian and overtly masculine overtone – the solution was for religion to replace addiction – to the industrial complex that is Oprah Winfrey promoting her own brand of self-help and empowerment (Travis, 2009). It is also possible to point to the connection between war trauma and the popularity of 'resilience' in military and

security policy. For example, Neocleous (2013) tracked the increase in usage of the term resilience over the last decade in US and UK security policy and at global organisations such as the World Bank and IMF. Eyre (2009) discovered in her study of firefighters who had experienced the September 11th attack in New York that the firefighters were encouraged to be resilient, rather than pursue help through counselling. Here, resilience, much like in the studies on grief carried out by Bonnano (2009), was a counter to the need for bereavement counselling. Rose (2014) has described the discourse of resilience as an optimistic one, replacing the anxiety involved in monitoring 'risks'. Resilience is understood as a natural human trait that can be taught, learnt and cultivated to alleviate and protect against mental illness.

5.4.2 Resistance to recovery

The optimism of resilience is evident in materials in recovery, for example from the South London and Maudsley's (SLAM) Recovery college prospectus:

Treatment and support from mental health professionals can be helpful but every person with mental health problems can become an expert in their own self-management. Whatever challenges you face, recovery involves finding the personal resourcefulness and resilience to take back control over your life and what happens to you. (South London and Maudsley NHS Foundation Trust, 2015, p. 19)

In this understanding, recovery is possible, no matter how serious the person's difficulties; service users just need to find their personal 'resourcefulness and resilience'. *No Health Without Mental Health* clearly stated that recovery was possible

for the 'vast majority' of people. Yet when recovery is always possible, and resilience is a natural trait that all possess if only enhanced, failing to recover becomes the (moral) fault of the individual. It is for this reason among others that the recovery model has received criticism from service users and others working within mental health care. Recovery is seen as a way of abdicating responsibility for mental distress elsewhere; that is to the person experiencing the distress themselves. For an increasing number of people, including the service users I interviewed, recovery is a shiny gloss on an unchanged and still coercive system, enabling cut backs on services, and eradicating long-term care through referring people to recovery colleges as a way to discharge them sooner (Braslow, 2013; Harper & Speed, 2012; Rose, 2014).

The recovery model has also been critiqued for relying on the standard 'deficit model' of illness it was originally designed to oppose (Harper & Speed, 2012). As one of the interview participants Eva described, recovery had become a "stick" used to measure people against. Eva described a culture within one of the recovery colleges where recovery was something one had to achieve and then maintain. By establishing markers of recovery such as the 'recovery star', it became possible for the relevant medical authority to make a judgement on whether or not someone was recovered. People then become responsible for adhering to prescribed ways of governing their lives, but the medical authority still remains intact – as psychiatrists become recovery experts and mental health care becomes 'recovery-orientated' and 'recovery-focused'. A contradiction then arises as recovery is described as a unique individual journey to self-control and autonomy over one's life, yet it is taught and learnt via a set of experts and in adherence to a set of predefined criteria. As the SLAM recovery college prospectus further demonstrates:

The workshops and courses we run aim to provide the tools (...) to help you become an expert in your own recovery. (South London and Maudsley NHS Foundation Trust, 2015, p. 6)

The outcomes of the recovery model have also been criticised for promoting normative values. Travis (2009), in her account of the rise of the recovery movement in the US, described the goal of recovery politics as inherently 'square'. But recovery politics is not only 'square' it has come to coincide with and reaffirm a neoliberal government agenda of autonomy and individual responsibility that has its interests in retaining the status quo (Braslow, 2013). A group of people have formed on social media website Facebook to express their disapproval at the 'neoliberal intrusion' on the word recovery in a group they have called 'Recovery in the bin'. The members of this group contend that 'recovery' has been colonised and used to discipline and control people with mental distress and argue for a 'Social Model of Madness', placing mental health within the context of the wider class struggle. Some of the group have claimed the title of 'UnRecovered' to replace 'Recovered', as a valid alternative and in rejection of the neoliberal and market values now infused in the notion of recovery. This refusal of recovery is also a refusal to 'tell our stories'. Once the central act of liberation from oppression, telling one's recovery story is now viewed as an obligatory gesture to justify and validates one's experience; a form of 'disempowerment, under the guise of empowerment'¹². This shift from 'Survivors Speak Out' to 'patient porn' (Costa et al., 2012) acknowledges the performative promise of recovery, where service users feel the ideology of recovery is merely 'lip service'.

¹² The Recovery in the Bin 18 key principles 2015: <http://recoveryinthebin.org/18-principles/> (Accessed 6 June 2016)

Recovery has become conflated with assumed notions of what it means to be a functional citizen yet the criteria of what is deemed to bring quality of life are rarely questioned. *A Journey to Recovery* (Department of Health, 2001) described the importance of recovery to the rights of a citizen, where those rights included: having an acceptable place to live, a meaningful occupation, access to further education and training, access to information on entitlements and benefits, and engaging in 'ordinary social activities'. This vague list of components of the happy recovered life mirrors much of the contributions of positive psychology. Yet as Rose has observed, 'For all that [recovery] goals are meant to be "personal", certain goals are not permitted. You cannot decide to go to bed for a month' (2014, p. 217). For instance, the recovery colleges deliver courses on how to stop smoking, how to eat better, and how to get a job. In these models of recovery there is an implicit judgement of how one should successfully live out their personal lives. As one participant Donna commented, it as though "you need to recover from being yourself". In the recovery model, 'ordinary social activities' become 'self-care' activities. From the online blog of the mental health organisation See Me Scotland one service user (Tate, 2014) described her frustration with how recovery had come to 'hijack' day-to-day existence:

I made the point that for many of us lunch is just lunch, those enmeshed in the recovery dogma may label it "self-care", a few glasses of wine after a hard day is just a few glasses of wine, the recovery dogma labels this "self-medication" (and that's bad!).

To recover from mental illness, to adhere to the model of recovery, involves a considerable amount of work on behalf of the service user. To recover involves a range of activities such as attending recovery colleges, completing recovery plans,

taking medication, getting a job, sustaining good relationships with others, eating well, not smoking, creating a new identity, being mindful and taking walks in nature. People using mental health services are increasingly finding themselves obligated to undertake this sort of 'recovery-work' in the promise of becoming well. A report entitled *Making Recovery a Reality* published in 2008 by the Sainsbury Centre for Mental Health describes how recovery can only be resolved if the person can gain hope. 'Without hope', the report declared, 'they cannot begin to build their lives' (Shepard et al., 2008). Recovery, like happiness, appears as a 'mirage', leading towards something that is not really there (Whitwell, 1999). The promise of recovery possesses a cruel contradiction in that the highly prized ability to become autonomous and have self-control to manage one's life is only possible through submitting to experts who help people navigate their way through to recovery. The service user is taught how and what to desire, all in the name of self-fulfilment and individual freedom. And because recovery is always possible it can only be the individual's failure of will or resilience if they are seen to relapse or fail to recover in the terms that have been proposed.

5.5 Conclusion

This chapter has covered a variety of cultural and political factors that frame grief and recovery. The space of grief and recovery is a terrain mapped by changing guidance and discourse, from the role of ritual and mortuary practices, to psychiatric diagnosis of mental disorders, the politics of happiness and the transformation of mental health policy. In this enquiry I have sought to delineate two themes shaping notions around recovery, emotions and grief. The first is the appearance of an increasing

medicalisation of mental distress and an unprecedented intervention of the government into the private and emotional lives of the population. The second is the acknowledgment that alongside this there is a celebration of the autonomous individual who is resilient, in control and has the power to make choices. At the centre is the formation of a subject: a subject that is at once liable to wrong decisions, whether grieving too long, being depressed or refusing to recover but then expected to be independent and autonomous. Autonomy and resilience can be cultivated, or recovered, but it is an autonomy that comes at the price of relying upon the advice of experts. The complicated griever, the wealthy but unhappy, the traumatised soldier, are some of these figures discussed in this chapter. These figures, through the discourse of recovery have found themselves bound to new authorities in the name of freedom, a relationship all the more subjectifying because the guidance offered appears to emanate from their individual desires (Rose, 1998, p. 17). There is, however, the echo of resistance against this 'obligation to be free', a resistance often voiced through stories and narratives. However, this is a resistance that embraces the forms of individuality and self-expression produced by the type of governmentality against which it is reacting. The privileged site of literature provides a platform for a variety of grief expression but arguably, it is a platform gained by learning how to tell the right stories.

In the next chapter I will attempt to pick apart the complexities of 'enacting' recovery in practice (McWade, 2015; Mol, 2008) through an analysis of how bereavement care is facilitated. By attending closer to bereavement counselling practice, and individual accounts of grief and recovery, I hope to illustrate how these discourses are negotiated in the everyday lives of those they seek to govern.

CHAPTER 6

Navigating the grief journey: The helpers

6.1 *Introduction to the chapter*

In this chapter I focus on the provision and organisation of bereavement care services across England. As I discovered in the course of my fieldwork, bereavement care is dispersed in different sites, often situated within or between clinical mental health services and the charity and voluntary sector. Due to this lack of centrality in the provision of bereavement care services, bereavement care was often delivered by volunteers with varying levels of training and utilised a number of different approaches. Therefore, in the first section I map out the state of bereavement services and organisations, setting the context for the accounts of my participants, all of whom worked in different capacities providing assistance to bereaved people. Then I pose the question precisely why bereavement, and the people who experience it, require care and management from experts and organisations ranging from the government to local charities. I argue that it is through the identification of ‘need’ and an estimation of ‘risks’ that has led organisations to identify bereavement as a public health issue. For the bereavement care professionals to whom I spoke, this ‘need’ was self-evident. However, I address how this need came to be identified through the calculation of the ‘risks’ of unattended grief, aided by the development of particular diagnostic tools brought about by the rise of psychology as a discipline.

The public health issue of bereavement has largely been addressed through psychological therapies and counselling. Since bereavement counselling has become

the default response to managing grief, I chose to interview bereavement care professionals as representative of the people who 'manage' grief. In the second section I present data from these practitioners and discuss the various models used by the counsellors and support workers interviewed in this study and how they were transferred into practice. What makes 'grief work' effective in practice was often described in more nuanced terms, where bereavement practitioners shied away from prescriptive statements. Despite this reticence, I highlight six components that emerged across the accounts and that my participants agreed were important to the success of bereavement counselling.

The reluctance to make prescriptive statements about grief work reflected how the term 'recovery' in grief and bereavement literature is contested and often controversial (Balk, 2004, 2008). Contrary to the embrace of recovery in mental health care services (see Chapter 5), recovery from grief was not something that was always agreed as being possible, indeed, recovery could seem like a dirty word. I introduce the 'Grief Recovery Method' (James & Friedman, 2009) as a contrast to the ambiguities of the bereavement counselling endeavour, and as an organisation that makes clear and strong 'truth claims' about the possibility of recovery from grief through the undertaking of a series of specific actions and exercises. In the third section, I discuss these conflicts as well as agreements on what recovery from grief entailed and how it was achieved, or not, through the assistance of the expertise of bereavement professionals. As highlighted in Chapter 2, there lies a tension between the proclamation of grief as natural and normal and the justification of external intervention into individuals' grieving. This tension persists in this chapter as I explore the facilitation of the grief process, where the knowledge of grief lies not in individual experience but the expert's understanding of it.

6.2 *The state of bereavement services in England*

In 2010 a report, commissioned by the Department of Health, was published that reviewed existing literature on bereavement care services (The University of Nottingham & Department of Health, 2010). The report aimed to establish what is known about current bereavement provision across the UK by reviewing existing literature on bereavement interventions. The nature of bereavement care, stated the report's authors, encapsulates a number of different services and resources provided by the health, education, social care, and voluntary sectors. They found that bereavement care was delivered largely in one of three different levels of intensity: (i) acknowledgement and information-based services; (ii) one-to-one support and/or peer support; and (iii) more intensive therapeutic and structured interventions for more complex grief reactions. The report also highlighted the gaps in knowledge around bereavement care services such as how much bereavement care services cost and the unevenness in the delivery of services.

The report reflected moves in recent years to better integrate and control the quality of bereavement care services, while maintaining the belief that bereavement is something that should remain largely a matter for community and social networks rather than clinical services. The Bereavement Care Pathways Project was formed in 2007 with the aid of a Department of Health grant, bringing together Cruse and the Bereavement Services Association, and aimed to bridge what was considered a 'gap' in the experience of bereaved people and bereavement services in the statutory and voluntary sectors. The project resulted in the publication of the Bereavement Care Service Standards (Bereavement Services Association and Cruse Bereavement Care,

2013) that detailed the 'Gold Standards' for bereavement care and established a clear 'bereavement pathway' to educate professionals and better connect up services and support. The Bereavement Care Service Standards provided criteria for what clients, carers, staff and volunteers should expect. This included auditing and ensuring equality and governance across different services; enabling 'quality control measures' to be utilised within the field; establishing a more integrated approach to the delivery of bereavement care; and providing a helpful benchmark with which services can be compared across the country.

6.2.1 The need for expert help

Although the position of bereavement care across different settings and sectors is still undergoing some clarification, the purpose of bereavement care is well supported. In Chapter 5, I described how mental health had been configured as a 'burden' on national economic resources, which provided the basis for psychological interventions into the nation's wellbeing and happiness. Bereavement is also viewed as an experience that has a detrimental impact on individual health. As Stroebe and Schut (2007) argued, bereavement has been associated with excess risk of mortality and morbidity. Bereavement is often related to a host of mental and physical disorders from cancer and cardiovascular disease (Richardson et al., 2013) to attachment issues and depression (Harrison & Harrington, 2001; Sbarra & Hazan, 2008). The risks are not only to individual health but also to the country's economy and society. A report (SECOB project research group, 2013; Stephen et al., 2014) published in 2013 sought to estimate the socioeconomic costs of bereavement in Scotland. Drawing on three secondary data sets, the researchers concluded that supporting spousal bereavement alone cost approximately £20 million annually.

Bereavement has other detrimental economic costs in the number of people who drop out of employment and take bereavement leave. The report called for a need to better calculate the socioeconomic costs of bereavement 'to improve self-management strategies and resilience in communities' (SECOB project research group, 2013, p. 4).

The National Council for Palliative Care, in partnership with the National Bereavement Alliance, published a paper in 2014 highlighting the need to address bereavement as a major public policy issue (National Council for Palliative Care, 2014). The report entitled *Life After Death* cited the report from Scotland, estimating that England's costs must be much higher at around £150-190 million to the economy each year. With deaths predicted to rise 15 per cent by 2035, the paper proposed six steps of action including a national review of the impact of financial, administrative and economic changes on those who have been bereaved and clear and organised rather than 'patchy' bereavement support. I argue the findings of these reports serve to reaffirm the belief in bereavement as both an individual and public health concern. The conventional response to this concern has been an increase in provision of bereavement counselling support. In Chapter 2, I described how grief came to be understood as an object of psychological study, one measured in normal and abnormal forms through the delineation of a grief process. The intervention of psychological therapies was founded on the basis of preventing or repairing the 'derailing' of the 'normal' course of grief (Shear, 2012).

For Rose (1997), the authority of psychology is justified through its claims to the truth of persons and their mental states. Rose argued the 'techne' of the confessional was employed by psychology, and created the emphasis on talking therapies in

overcoming mental distress. A new relationship between psychological experts and those who consult them was thus formed, that Rose (1997, p. 93) described as a kind of 'discipleship':

The relation between expert and client is structured by a hierarchy of wisdom, it is held in place by the wish for truth and certainty, and it offers the disciple the promise of self-understanding and self-improvement.

The growth of psychology as a discipline and the tools and measures it developed provides an explanation of why grief, as it became an object of study for psychology, found its means of cure through psychological counselling interventions. However, there is considerable debate and questioning among researchers over the empirical value of grief counselling and whether 'grief work' actually works (Jordan & Neimeyer, 2003; Larson & Hoyt, 2009; Schut, 2010; Stroebe & Stroebe, 1991).

A number of reviews have claimed that grief counselling is ineffective and potentially harmful, finding that the 'scientifically demonstrated efficacy' of formal interventions for bereaved people is 'distressingly low': far below other types of psychotherapeutic intervention (Jordan & Neimeyer, 2003). A more recent review concurred with these findings, describing the overall quality of studies of bereavement intervention as 'poor' with results showing 'mixed effectiveness' (Waller et al., 2016). These findings that Jordan and Neimeyer (2003) regretfully note as 'surprising' and 'upsetting', contrast the powerful discourse outlined in Chapter 2 that began with the interpretation of Freud's 'Mourning and Melancholia', that grief is something that needs to be worked through with the assistance of a psychologically trained expert. Counselling has become a standard response to all forms of traumatic event, yet as

Groopman (2004) discussed, the benefits of the common procedure of 'debriefing' after traumatic events lacks scientific evidence. Further, Groopman presented cases where debriefing and counselling interventions produced unwanted negative effects on survivors.

How precisely 'recovery' is measured in proving the 'effectiveness' of an intervention remains debatable and presents a major problem in evaluating the success of bereavement counselling. The effectiveness of an intervention in the studies detailed above is based largely on the researcher/therapist's estimation of the reduction of symptoms, not a self-reported account from the client.

However, the need for bereavement counselling and support is portrayed by bereavement organisations, not as politically or economically directed, but as driven by those experiencing bereavement themselves. This belief is supported to an extent by empirical evidence such as the nationwide survey conducted by organisation Dying Matters¹³ that polled 2058 adults in the UK. The survey revealed that one in five (21 per cent) bereaved people declared they wanted to talk but could not find anyone to listen (Dying Matters, 2014). These findings highlight at least some need for listeners in the event of bereavement, albeit not a universal need and, indeed, not necessarily listeners who come in an expert form. This concurs with the common understanding in counselling work, and repeated by the participants of this study, that maintains that the client has to be willing to talk and do the work, otherwise the role of the counsellor is redundant. An alternative way of thinking about this 'need' to receive counsel or be listened to could be construed as the result of an increasing

¹³ Dying Matters is a coalition of 32,000 members from organisations such as the NHS, voluntary and independent health and care sectors, the legal profession and the funeral sector across England and Wales which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

reliance on the psychological sciences to provide remedy to the troubles of daily existence. Bereavement counselling is thus another extension of the 'psychologisation' of everyday life. The need for a therapeutic response to grief becomes self-explanatory once those who have been bereaved come to understand and relate to themselves and their grief as matters of the psyche to be resolved via a working through of the emotions.

6.3 *What makes 'grief work' work?*

Here I draw upon data based on the insights of interviews with bereavement counsellors and support workers to answer the question: what makes 'grief work' work? As outlined above, the answer to this question is not always explicit, even to those who practice bereavement counselling. For the participants, grief was certainly something to be 'worked through' individually or in collaboration with a bereavement care professional, with any failure to work it through leading to negative consequences and a failure to recover or resolve grief. The components of 'working through', however, could vary. In this section I highlight six criteria that aid successful grief work, as described by the practitioners, but I also highlight how they were often interpreted and implemented differently. The six key features I discuss are the types of counselling approaches and method employed; the making of the bereavement 'expert'; how clients are assessed to receive treatment; the importance of safety; counselling as normalisation and the role of emotion work.

6.3.1 The type of counselling approach and method

In general, the psychological method demands statistical evidence to *prove* the significance of its endeavours but within bereavement research there is inconclusive and conflicting findings over not only what comprises grief work but also whether counselling is the most appropriate means of its facilitation. Despite, or because of this, there is a deluge of models that seek to address and explain the grief process. I found the counsellors and support workers who participated in the research deployed a number of models of grief in their practice as well utilising humanistic counselling approaches. My data showed that the approach employed by the majority of counselling practitioners was a client/person-centred model derived from the work of Rogers (1951) drawing on an eclectic approach. The person-centred model was central to Cruse volunteer training. The Caris counsellors had completed or were undertaking counselling qualifications before working as bereavement counsellors. Consequently, Caris counsellors tended to have a broader range of influences in their approach. Some counsellors demonstrated an integrative approach that touched upon a number of different theories and techniques including Bowlby's attachment theory, Gestalt therapy (Wertheimer, 1938), mindfulness (Kabat-Zinn, 1994) and references to psychodynamic approaches and utilisation of concepts such as transference and counter-transference, the unconscious, and an emphasis on childhood experiences (derived from the work of Freud).

Rogers' (1951) person-centred approach emphasises the client as expert. It is a non-directive approach that holds that the client knows her or himself best. The role of the counsellor is to be skilled in empathetic understanding and non-judgmental listening in order to allow the client to express their feelings. Roger's theory is reliant upon the

idea that humans have an inherent potential, and tendency to growth and wholeness. This positive view of the person is the 'organismic self', which innately seeks self-actualisation. However, people also possess a 'self-concept' produced and affected by others around them that can conflict with the organismic self if one's self-concept becomes distorted. Someone's self-concept can become distorted when there is a lack of positive regard and approval from those around them. Thus, the role of the therapist is to enable the client to become fully functioning and bring congruence between the phenomenal field of experience and the conceptual structure of the self. If achieved, this would represent freedom from internal strain and anxiety, and the capacity to use talents and abilities, realise potential, move towards complete knowledge of self and maintain responsibility for determining one's actions.

The participants also drew on grief models with many making reference to the dual process model (Stroebe & Schut, 1999) (nine out of twelve participants), along with Worden's tasks (three participants made explicit reference), continuing bonds (mentioned by five participants) and the stages of grief (also mentioned by five participants). Also popular were the ideas of 'growing around grief' conceptualised by Tonkin (1996) and the 'grief wheel' (see Figure 2). These models featured in the grief and bereavement specific training that the counsellors and volunteers received at Cruse and Caris, and were used in an "integrative" way. The models were often referenced by practitioners as useful tools to measure where a client was in the process, who also stated they were helpful for the client to "normalise" their emotions. As Cruse support worker Susan (BSW1) described using the dual-processing model with her clients:

That model's very useful (...) it gives you a visual idea (...) It's sort of a bit of

evidence that you can see in a visual way that things are progressing and is taking its natural course, however long that may be.

Caris counsellor Wendy told me that she found Worden's tasks model useful when dealing with clients who "seem quite stuck" and the stages model as helpful for someone "who's got some sort of abnormality in their grieving". Here models were used in a pick and mix fashion depending on "the individual and their pathway", and "making use of whatever is available". The 'growing around grief' idea by Tonkin helped Susan to assess how integrated her client was becoming in the "normal world".

Representatives of the organisations to whom I spoke employed different systems for the number of sessions a client received. For example, Cruse and St Christopher's had a limit of twelve sessions, offering six sessions in the first instance. Caris was unusual in that it offered an open-ended service, where counsellors had an opportunity to build relationships over time with clients: a difference the counsellors believed affected how they worked. Often time limitations were due to organisational restraints that demanded proof of the success of the intervention. Wendy at Caris described how the nature of bereavement actually required long-term counselling, and unlike other "goal-centred" problems cannot be dealt with in a "brief" way:

The problem with bereavement is it isn't an easy goal-centred problem. There's lots of things you can deal with in a brief way because you can just leave out the other stuff and deal with the main, whatever the agreed thing is, and like a dentist you don't have to do all the teeth at once. But with bereavement I think you probably do, it doesn't work really to focus just on

the one thing. (Wendy, BC1)

By way of contrast, the Grief Recovery Method (GRM) clearly states it is not counselling or therapy. The Director of Grief Recovery UK, Ellen, appeared quite dismissive of bereavement counselling and of the service provided by Cruse. Speaking of her experience: "I've had counselling, I think what they call person-centred, whatever that means, and I really didn't like that". Ellen was critical of the lack of choice in bereavement care and described it as a "disservice to the bereaved". For her the GRM presents something very different, and better. Ellen told me: "It's my goal that by the time I retire people won't say Cruse automatically they'll say Grief Recovery. That is my mission to knock Cruse off that".

The GRM is a series of steps, described in the *Grief Recovery Handbook*, first created by John W. James. The steps involve a number of activities that must be followed in the stated order. For example, the first step is to write a 'loss history graph', which details all the losses people have experienced in their life, loss being broader than death, encompassing 'the loss of hopes, dreams and expectations'. The second step is to write a 'relationship history graph' for the relationship people wish to find 'completion' with. This graph documents the key aspects of a relationship with the chosen person (deceased or alive) on a timeline. The final step is to write a 'completion letter' to the person, which again has a very strict format, detailed in Section 6.4.1. The key to each activity is that the letter had to be read out to another person. Along the way there are a number of exercises and concepts to learn from the 'six myths of grief' to 'short-term energy relieving behaviours' (STERBs). For Director Ellen the novelty of this approach was not to be understated:

Now I believe, that until John James put the words grief and recovery together nobody else had (...) and that's why we changed our name from grief recovery to the grief recovery method, so that we could trademark it.

When I asked Ellen whether the GRM utilised any of the other dominant grief theories, she replied: "Nope. That's all head stuff". The GRM is against "intellectualising" grief declaring that grief is a matter for the heart. The dominant ideas around grief were thus ignored by the GRM, due to the fact they were seeking an "intellectual solution to an emotional problem". Ellen told me that the 'growing around grief' idea made her "angry" because it's "simply not true". Rather, in the GRM grief is "chucked out" and gotten "rid of" through completion.

In Section 6.4 I explain further the differences in perspective among the participants concerning what recovery from grief involves. However, here I want to note the seeming ambiguity in the role of the bereavement helper who in different settings occupies the position of counsellor, support worker, volunteer or 'coach' who provides a 'toolkit'. In the rest of this chapter I intend to separate where possible 'counsellor' and 'bereavement support worker' to acknowledge the difference in levels of training among the participants. I have provided each participant with an identifier such as BSW1 or BC1 to distinguish between bereavement support worker and bereavement counsellors, as described in Chapter 4, Section 4.3. Furthermore, in bereavement work and in contrast to work within mental health care, personal experience of bereavement is often a desirable feature of a potential candidate that can substitute for any lacking in formal counselling qualifications and training, as I describe next.

6.3.2 The making of the bereavement expert

A lot of us have got backgrounds with personal experiences, which has led us to do what we do now. So you get a connection - it's not formal counselling, it's professional we are all properly trained and its professional -but at the same time there's lots of empathy, and can't say friendliness but just connection and empathy. (Susan, BSW1)

Like Susan quoted above, the majority of bereavement care practitioners I interviewed spoke in some capacity of their own experience of loss and how the knowledge of loss either provided them with the incentive to become a bereavement counsellor or how it enhanced their work. Susan described how at Cruse “a lot of the counsellors and supervisors” were drawn to the work at Cruse because of their own experiences. Many of the participants told me of their own personal experience of loss in order to explain why they became engaged in bereavement work. Getting involved in bereavement counselling was a way to “give something back” and do something “positive” following their loss. They also told me that having such experience meant that they had something to offer as counsellors, even without formal counselling training. This, some of the participants claimed, was because the mutual experience of loss was considered to produce a “connection” where the potential counsellor could “understand how it feels”. A personal experience of grief was considered to complement the person-centred approach to practice that encouraged the counsellor to imagine and feel the world of the client, despite the Rogerian approach encouraging empathy rather than sharing the experience. In one case, it was not even the experience of bereavement by death that led her towards

bereavement counselling: Caris counsellor Claire described how her experience of illness impacted on her:

I felt, I know something about loss, and I know something about looking at it in the face in a way and finding meaning in it. And I think that was, I think that was what led me to think yeah bereavement counselling is what I will apply for. (Claire, BC5)

In all cases, being aware and reflective about one's own 'loss background' was included in the bereavement counselling training, albeit in different measures. At Caris, for example, counsellors would create their own 'grief map' of losses experienced in their own life. This was understood as part of the necessary personal development of the counsellors that would bring to awareness any 'unconscious' thoughts and feelings around grief and bereavement that might become problematic in the counselling encounter and prevent the counsellor from listening to the client. A background or experience of loss might be a key incentive to getting involved in bereavement counselling, but the personal experiences of the counsellor should not enter into the counsellor-client encounter.

Grief Recovery UK explicitly embraced the practitioner's personal experience of loss in the training of their 'grief recovery specialists'. In fact, personal experience was considered key to being able to train others. At the Grief Recovery training workshop I attended, all trainees had to undertake the 'personal workshop' which had to be 'completed' in order to undertake the extra day of specialist specific training. Further, being able to speak about one's own experience is key to the method. As Ellen the Director described:

We don't use a professional mask in grief recovery we don't make our faces blank, we show our human emotions and we share our personal stuff which is a complete no-no [in other methods].

Ellen here was highlighting the difference between the GRM and counselling where personal disclosure is not standard practice; indeed disclosure from the counsellor goes against the counsellor/client contract. In the GRM the idea is that the “leader goes first”. As demonstrated at the workshop, Ellen showed us her own loss history and relationship graph, spoke openly and copiously about her deceased husband as well as her father and even her current relationship and wedding plans. She noted: “Counsellors would never do that. No, no, no”. Within the GRM however, the emphasis is on “telling the truth” and showing “real’ stuff”. The claim to ‘realness’ is a repeated theme, displayed clearly in another publication *Moving Beyond Loss* (Friedman & James, 2013) which is subtitled: ‘real answers to real questions from real people’.

Speaking about one’s loss history was thus used to reveal the ‘authenticity’ of the GRM in contrast to the ‘masks’ of counsellors. Yet arguably, the ‘mask’ of counsellors is a means to create important boundaries between counsellor and client. For Ellen, the principle of ‘leader goes first’ created ‘safety’ but it could also create confusion. At one point during the facilitation of the Grief Recovery workshop Ellen began to cry as she went through her ‘relationship graph’, asking one of the group to give her a hug. Listening to other group members in training the following day questions were raised over her credibility, insofar as some being unconvinced she had gotten ‘over’ the death of her husband. Even Ellen was somewhat aware of the confusion:

It’s a really bizarre thing, I have to constantly tread this fine line between

Ellen the widow and Ellen the Grief Recovery specialist. So I wear the two hats.

This was in contrast to how Caris counsellor Wendy spoke about the boundaries of the counselling setting. These boundaries existed not only in the counselling room itself but needed to be embodied by the counsellor. Wendy believed the lack of strength of these boundaries would then show themselves when the counsellor was taken outside of the familiar setting, to a client's home, for example¹⁴, where the counsellor and client were away from the familiar props of the counselling encounter:

My view on it is the boundaries only became confused if the counsellor is confused about what counselling is. And you can be in a consulting room because someone else set the room up, you can appear to be a counsellor much more, but actually fundamentally if the boundaries are confused in the home setting then that's because the counsellor is confused. So it shows up weak counsellors more but if you're not a weak counsellor then it's a marvellous setting (...) so there has to be an ownership on the counsellor's side about what boundaries matter and what one's don't. (Wendy, BC1)

However, as the GRM does not claim to be counselling, the parameters were quite different. The role of the specialist is to "teach the steps" of the handbook: "We're not messing about with your head, we're not analysing anything", declared Ellen. Subsequently, the potential specialists need not undertake formal training or an application process. Instead they were required to attend the four day workshop¹⁵,

¹⁴ Caris also undertake counselling sessions in clients' homes.

¹⁵ The personal Grief Recovery workshop is priced at £295 for three days. To become certified as a specialist, the fee is higher (not disclosed on website).

and have “an open mind and open heart”. Following the workshop, people were then ‘licensed’ as ‘Grief Recovery Specialists’ to either set up their own one-to-one or group sessions using the GRM, charged at a price of their choosing, or incorporate it into their existing work. The GRM is also endorsed by the British Association for Counsellors and Psychotherapists (BACP) to be taken by trained counsellors and psychotherapists as part of their continuing professional development. This endorsement by the BACP might appear contradictory considering the GRM’s opposing beliefs on counsellors sharing personal information with their clients.

6.3.3 Assessing clients for treatment

Clients were given different forms of assessment to judge their eligibility for counselling. At Caris, I spoke with Linda who carried out the assessments on all potential clients. She described to me the process:

What is it I need to know about this person? (...) I’m going to meet them once and therefore I just need to make a sound assessment that takes into account risk factors, that takes into account history and how the history of that person would be indicator of how they manage grief now. (Linda, BC2)

Along with a list of questions around the bereavement, Linda’s assessment sought to estimate the ‘risk factors’. Risk factors included suicidal thoughts, self-harm or ‘risky behaviour’. These forms of ‘risky behaviour’ were elucidated further in completing the CORE-10 (Clinical Outcomes and Re-Evaluation)¹⁶ screening measure that is commonly used in mental health care practice to screen for signs of depression and

¹⁶ Copyrighted by CORE Systems Trust: <https://www.coresystemtrust.org.uk/instruments/> (Accessed 6 June 2016).

suicidal thoughts by asking clients to agree with a list of statements such as 'I have made plans to end my life' or 'I have felt unhappy'. Thus assessing eligibility was also about assessing potential risk. Cruse's Early Intervention Project (EIP) established in 2013, is a service designed specifically to target 'those most at risk of developing prolonged grief disorder'. It aims to be a 'fast-track service' to avoid the long waiting lists Cruse often has. To qualify for the service the client has to be no more than six months bereaved. More than that qualifies someone for the diagnosis of 'prolonged grief disorder'. The EIP assessment seeks to identify any risk factors that suggest someone will develop 'prolonged grief disorder'. When I visited the EIP office, the manager of the service listed to me the risk factors used on the EIP assessment forms:

- How close was the relationship to the deceased (were there dependency issues)?
- Did they die in hospital?
- Was it a sudden/unexpected death?
- Did they have a problematic childhood?
- Any current or previous mental health conditions?

Many services warn against people accessing them too soon after bereavement. However, Grief Recovery UK took a different approach by helping people immediately after bereavement. In the GRM the only qualifying criteria was a "broken heart". Within the GRM "fresh" grief was actually favoured for people who had not yet 'pushed down' the grief, forming the "cut" of grief to an unwanted "scab":

It's like picking off the scab isn't it, it hurts when you're picking away at it, afterwards when it's come off it feels better because it's not itching anymore. So they've got the itch, they don't want to face up to the picking at it,

but when the cut's just happened, if you could go straight from cut to clean bit you would wouldn't you? (Ellen, GRM)

The hesitancy around encouraging people into counselling too early is the general hesitancy in bereavement care to medicalise 'normal' grief. The GRM assumes that all grief needs some level of work and help and can find 'completion' through the method. Introducing people at the earliest possible point means no time is allowed for the "scab" to be formed.

Overall from my data show how key criteria of eligibility for grief work beyond the risk factors was simply the client being "ready to do the work". The assessment procedures documented the observations of the counsellor and their judgment of the client's suitability, but the appropriateness of the intervention also depended on the client's apparent willingness "to make the journey", as described by Caris counsellor Claire. However as Claire acknowledged, while working through grief may be like a journey, it's a journey that's "not for everyone". Embarking on counselling was a choice, but one bounded by a set of rules and the counselling method. This can be seen as part of the contract between counsellor and client where counselling also aims to "give people the opportunity to make choices" (Wendy, BC1). Unwillingness to do the work could be read in different ways, and I will return to this point later in discussing how 'resistance' is defined.

6.3.4 Counselling as normalisation

And it was almost when I gave her permission, to say look it's completely understandable and it's completely normal that you would be upset (...) It's

completely normal to be feeling the way you're feeling (...) and so to be able to dispel that myth, to help to normalise feelings, because I think that's a big part of bereavement counselling: it's about normalisation. (Linda, BC2)

As Linda described, my data show that a big part of bereavement counselling is about “normalisation” and “normalising feelings”. However, there was some ambiguity around how ‘normal’ and ‘abnormal’ were defined. Grief was described as individual and unique but then also a ‘process’ that was ‘natural’ and ‘normal’. Normal and natural were often used interchangeably and when I explored with participants what was meant by ‘normal’, many of the practitioners had difficulty providing an easy answer. It was emphasised that normal could be quite broad. Describing the activity of ‘normalising’ grief was intended to make people experiencing grief feel better, rather than to state there is a ‘normal way’ to grieve. As Daniela put it: “When I talk about normalising emotions it’s more about being in a world where it’s okay to feel like all you want to do is lie on the ground and stare at shoes”. But normal was also a measure aided by models of grief, or as Susan mentioned, “photocopies of all the emotions” that she would use so that clients could “see them all written down” and learn that what they were feeling was normal, “it gives them something concrete”.

Normal emerged as something to be achieved, as something that has been lost in grief, yet at the same time the grief process itself was judged as normal or not. The use of the term ‘normal grief’ implied some form of movement forward, in contrast to those who got ‘stuck’. Cruse bereavement support worker Susan used the ‘growing around grief’ model to measure clients’ return to ‘normality’. Susan drew me a diagram to demonstrate, drawing “the grief” as a circle in the centre and then circles that would expand around the grief, as she described:

And so you can, after the first few sessions you get a feel if they are totally immersed in all that or if they are not, you can start (draws circle) went back to work for two weeks you can put that outside there, meet up with friends now and again. So that's the grief but (...) a person's got a little bit, is in the normal world (...) so even though that's their grief, there's a bit of normality going on, restoration if you like round there. (Susan, BSW1)

Grief could be categorised into types, whether “straightforward” and “run of the mill” or “complicated” and “risky”. Cruse’s Early Intervention Project, for example, aimed to identify ‘complicated grief’ even before it developed into ‘prolonged grief disorder’. Thus “complicated” grieverers were separated out from the “run of the mill” grieverers. Participants’ inability to express clearly what was normal highlighted the conflict that, at times, appeared when emphasising both the individual and unique feelings of the grieving client and the belief in a ‘natural process’ of grief. I return to the ambiguity of normality in Section 6.4.1 when I discuss how recovery is negotiated in practice.

6.3.5 The importance of safety

The participants emphasised that normalising emotions also helped produce safety in the counselling encounter. The building of a “safe space” emerged as an important component in grief work. A safe space was created in a number of ways, crucially by the building of the client-counsellor relationship, so central to the person-centred approach. In all approaches confidentiality formed an important part of the contract. Showing one’s expertise as counsellor also created safety. In the GRM this was

ensured by the 'leader goes first' policy but for Cruse clients viewing the counsellor as professional and 'properly trained' formed safety. Creating a safe space enabled clients to "offload" and release previously hidden or unconscious emotions. The role of the counsellor was to be someone who could sit with the seemingly unbearable nature of grief, as Wendy described:

So the client is actually in a relationship at last that allows them to cry or not cry. Can stand it if you do cry, can stand it if you don't cry and doesn't have an agenda about it. And that subtle something transpersonal or unconscious that goes on between the client and the counsellor because it's not so much what's said it's just, sometimes you're with a person and you know it's just alright if I burst into tears. (Wendy, BC1)

For Wendy safety was often a subtle, unspoken and unconscious agreement between the counsellor and client, formed by the strength of the relationship. Adhering to boundaries and the contract of the counselling encounter developed a strong, safe relationship. Within the safe space the unconscious could be slowly allowed to "perk up to consciousness". As Wendy explained, the unconscious was normally kept guarded, but the barrier could loosen its grip and a "flood" of thoughts could appear, thoughts the client may not have realised they had. It was as though the space formed between the counsellor and client allowed the release of emotions that could not find release anywhere else. The safety of the space also provided important boundaries that could hold the emotions of grief, and find room to undertake the crucial working through of the emotions.

6.3.6 Emotion work

We are working with the emotions, grief is all about emotion. (Ellen, GRM)

As Ellen identified, grief was all about working with the emotions, and the participants drew on a variety of, sometimes conflicting, metaphors and images to describe the work of grief. Grief was often described as a space to be worked through and moved out of: "You can't go round it, you can't go under it, you can't go over it, you have to go through it" (Ellen, GRM). But grief was also described as something that was "inside" the person that needed to be "externalised". For example, grief work was described as "pulling", "hoiking" and "bringing up emotions". Yet emotions and grief also had a life of their own and could be resistant to being managed. Emotions were viewed as "fluid" and unable to be contained. Emotions could inhabit different bodies and be "transferred" on to different people. Daniela described how in transferring feelings of grief, people may not recognise their feelings until another bereavement or loss:

(...) because they'll then transfer those feelings on to something else or someone else. Or say for example you had a mum and a dad, and the dad died and the mum and the dad had divorced and the kid was always, grew up with the mum and the mum would say oh that's a terrible person and then the dad dies. The kid's still not allowed to grieve for the dad because mum's still there and mum's still saying what a terrible person this was but when mom dies you lose your mom and then you also go, 'shit I lost my dad as well!' (Daniela, BC3)

For this reason, as trauma counsellor Tony told me, emotions had to be “worked through” and “dealt with” otherwise they would “catch up with you” and “come back and bite you on the bum”. In these differing interpretations, grief was both something to be actively moved through but also something that moved the individual. Grief was something inside to get rid of or outside the person and in the way. Similarly, the emotions that were provided by the person when they were alive, in particular if they were bad or abusive feelings and not only positive, could leave a space in the bereaved person’s life where they look for ways to inflict that feeling upon themselves. Daniela (BC3) described to me this transfer of emotions, which led to further discussion:

Daniela: This person might go and then I won't have this shitiness so where am I going to get this shitiness from? I'll have to do the shitiness to myself.

Interviewer: I'm thinking about how people internalise an emotion. It's almost like that feeling is there but it can inhabit different bodies.

Daniela: Yes it's like a possession. It is like a possession, which I am only realising now as I am talking about it, which is making me very interested.

Interviewer: What is the task then when someone has taken on these feelings, is it to try and get rid of these feelings?

Daniela: I guess it would be getting them to see that, to acknowledge it (...) how can you do that for yourself now that they've gone, now that role is no longer there's. Can you take on that role for yourself (...) I mean that's the whole thing: what's your shit, what's somebody else's shit.

The client was provided with different forms of agency in each interpretation, either as possessing the control to move out of grief or possessed by grief itself, unable to

resist the emotional sway of grief. My data show, as Árnason (2007) and Anderson (2001) both identified in their studies of the imagery used by grief counsellors, spatial metaphors were employed that assumed an individual inner space, what Rose (1985) termed the 'psy' space installed in the modern individual. This inner space conjured the 'murky' depths of the client from which emotions could be 'brought up' and 'worked through'. Emotions were not always visible to the person experiencing them, but they could be named and identified by the counsellor, in an activity Claire (BC5) described as "colouring in a picture together". The counsellor 'gaze' (Foucault, 1973; Rose, 1989) was enabled by the capacity to name and identify emotions and thoughts, colouring in the unknown depths of the client. My data showed that what presented initially in the counselling encounter was not what was important, suggesting that the 'true' emotions could only come to light through the counselling process. These methods also required particular displays of emotions, so that crying was described as "raw" and authentic and laughing as "avoidance". This emphasis on the 'truth' of tears was most evident in the GRM, where at the workshop tears were expected: we were given tissue boxes on our arrival. When a small group of the workshop attendees found themselves laughing during an activity they were swiftly told to keep quiet by the group leader, laughing being an activity of avoiding truth, a 'short-term energy relieving behaviour'. The encouragement to show emotions thus appeared to be limited to particular types of emotions. The appropriate type of emotional display was important because in each case emotional expression had been endowed with the claim to truth. It seemed whether one laughed or cried was not just a transitory affect of the body but a reflection of the deep inner workings of the psyche.

6.4 *Agents of change*

In this section I discuss how counsellors and bereavement support workers aimed to facilitate change and recovery. In Section 6.3 I highlighted some of the key components of 'grief work' that laid the foundations for the possibility of change and recovery. Arguably the counselling contract is established in the belief that people can (and need to) change and transform. Using Foucault's ideas around building an 'aesthetics of existence', I explore how the facilitating of recovery and change presents an opportunity for the 'crafting' of the self, for creating oneself as a 'work of art' (McDonald & O'Callaghan, 2008). Counselling is a form of work based on the psychodynamic tradition of "picking apart your perception of yourself" in order to "rebuild it stronger". This notion lies at the heart of the therapeutic endeavour, as Daniela (BC3) described:

[S]omeone described it as all of your clothing and all your skin and bone and everything just being taken off and you're just this quivering little thing. (...) Then it's about putting stuff back together again. But in the way that you want it to look like, not in the way that you've had to make it look like.

Daniela here describes the crafting process, remaking oneself in the image one desired. Implied in this notion was the belief in a "thing" underneath all the "clothing", "skin" and "bone" that could be transformed and rebuilt. I then asked Daniela (BC3) what she thought that thing was, once everything has been stripped away, she replied:

The essence of the person, their spirit, the soul. The potential. I think I like that word more. The potential of the person. That's what I think is there. Once everything else has been stripped.

This 'thing' was described differently as "essence", "soul", "spirit", and "potential". The word potential fits well with the ambitions of counselling and the belief that everyone has the capacity to flourish, a potential that can be nurtured, or indeed hindered in different ways. As mentioned earlier, the contract between counsellor and client also assumed that both parties were ready and willing for a transformation to take place. For bereavement counsellors the change is brought about by the method they use: talking therapies. Talking about one's feelings in such a manner was seen to initiate the change and enable 'movement' and a 'reconfiguration' inside the person. In the GRM following the steps in the required order was what brought about change. In each approach a method needed to be adhered to by the client under the promise of change and transformation. The components above are cited as providing the right environment for change to occur, such as establishing safety in order for people to "vocalise their pain" and to talk about their feelings. Yet though the components of grief work seem fairly clear, how change actually happens did not appear to have a set formula in bereavement counselling. This contrasts with the GRM that has a clear pathway to 'completion'.

In what follows I seek to uncover two different types of transformation: one that leads to recovery and another that leads to non-recovery. These were commonly described as "movement forward" and "stuckness". These descriptions mirrored the contrast between linearity and liminality, which I have emphasised throughout this thesis. I hope to describe how recovery and non-recovery were negotiated in practice

and what sorts of explanations were provided in the instance of failing to recover. While failure to recover was not necessarily agreed to be a transformation in the same way as recovery, I argue that such a failure is as much a production of the bereavement counselling process as recovery. Failure is not a question of blame I suggest, but a product of a process that is shaped so that anything less than recovery (in the terms proposed) is a failure of the individual. Viewed in this way failing to recover becomes less a faulty choice of the individual, explained through moral weakness, and more a type of description achieved by fulfilling the right criteria, behaving in a certain way or by the showing, or concealing of particular emotions.

6.4.1 Negotiating recovery

One of the key questions in this thesis is to ask what constitutes recovery from grief. In the literature, reviewed in Chapters 2 and 3 the answers to this question were far from conclusive. In Chapter 5, I further analysed how the concept of recovery has been taken up and embraced in mental health care yet, in the process of mainstreaming, the meaning of recovery has arguably become hollow, used only as a rhetoric that seeks to reaffirm dominant political agendas.

Recovery from grief is particularly contentious in grief and bereavement research and theory and, as I have documented so far, straddles an uneasy divide between the emphasis on grief as 'natural' and grief as having a 'normal', staged process. As Paletti (2008) identified, there appears to be an epistemological divide between researchers and practitioners over the use of the concept of recovery, a divide I explore in the remainder of this chapter. Counsellors and those who work with bereaved people have an investment in helping them to recover, or find relief from their grief. In the

data from bereavement counsellors and support workers the term recovery was embraced, yet more often different terms were preferred such as “integration” or more subtle explanations that grasped at ideas of “movement” and the client ‘inhabiting’ new identities. Grief was less well suited to the discourse of recovery than, for example, mental disorders, as what has been lost cannot be recovered. In bereavement counselling there is no resolution of the initial problem, as Wendy (BC1) explained:

Well I do say to our counsellors that bereavement counselling is just about the only counselling where there is no resolution of the initial problem. If you come to a counsellor with a phobia you can just get over the phobia, or come to the counsellor with some childhood issue and work through it, but actually you can never bring back the person who died and so actually what the counselling is about is coming to terms with the fact you can't mend it, there's no mending this issue.

It is around this final problem that bereavement counselling and care is positioned as providing different but never quite complete solutions to grief. Formal measures are used in practice that aimed to capture a client's recovery; these include the CORE assessment forms. Though not designed for grief, these are used to measure a client's general mental state before and after a series of bereavement counselling sessions. Linda, who managed the new client assessments at Caris, described how the CORE-10 and CORE-OM forms helped show the “effectiveness” of the service but also by comparing the forms before and after the counselling intervention allowed the client to “see their own progress almost in black and white”. Grief models were also used in counselling sessions to enable clients to see their progress. Susan drew out the ‘dual

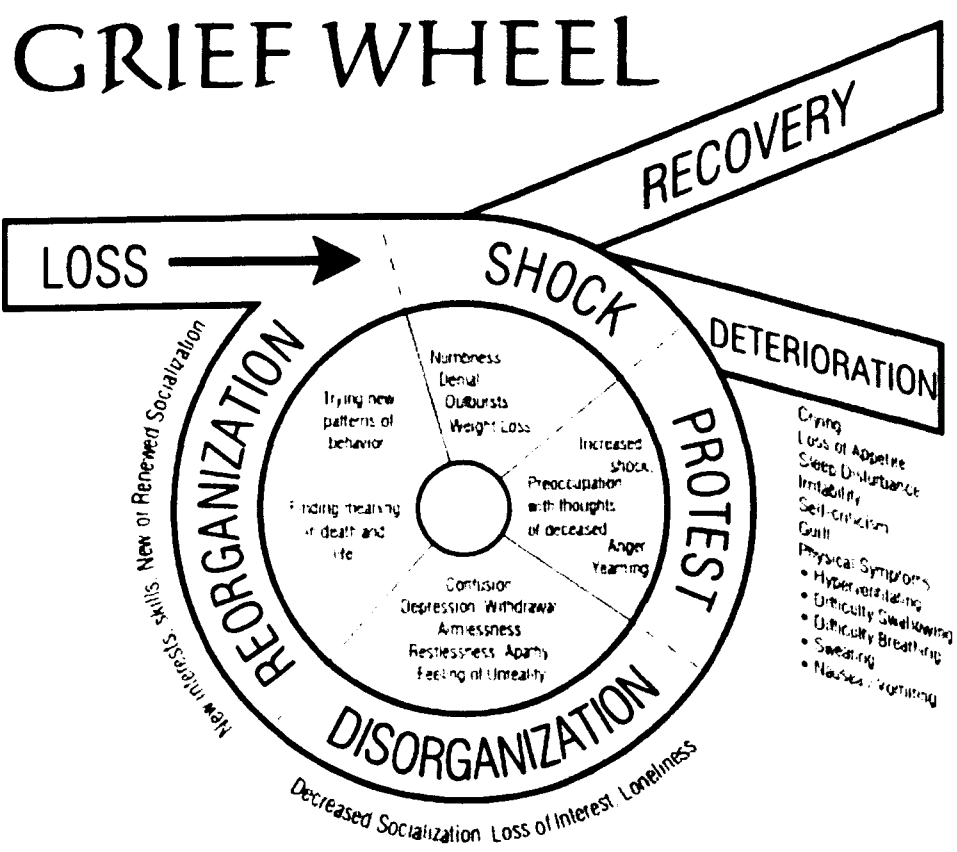
process' and 'growing around grief' models with clients which she claimed helped them see how well they were coping and how they were integrating back into the "normal world":

So it's your new life that has emerged and that's the nice balance, you've got a nice big new life with your interactions and new relationships, friendships, whatever. It's never the same again (...) when you restore back into recovery, whatever you like to call it. It's a new life; it's a different life, you don't go back to the same old life. But the lovely idea being that the grief where this person that you have lost is integrated within your new life. (Susan, BSW1)

Linda, who used the 'grief wheel'¹⁷ with her own clients, explained why recovery was depicted as the higher point to represent hope and what has been 'gained' from the loss. In the 'grief wheel' recovery was depicted as an upward movement that could be achieved as long as one avoided 'deterioration' and stayed on course. In the 'grief wheel', recovery was defined as 'accepting the loss and having an increased interest in socialisation, new lifestyle and behaviour patterns and having a greater sense of meaning and purpose'.

¹⁷ There are a number of variations on the 'grief wheel'. Figure 2 displays the version used by the counsellors at Caris.

Figure 2 The grief wheel



The grief wheel, and its companion models and measures, sought to provide a road map for both client and counsellor as they navigated grief and negotiated recovery. Behind the tick boxes however, grief often did not follow a straightforward journey. The Cruse Early Intervention Project also used the CORE-10 to measure progress in their clients. The statistics for 2013-14 displaying a 38 per cent improvement over the six-session treatment were proudly shown to me on my visit to the EIP office. The use of a further tool, the 'bereavement compass', presented a 33 per cent improvement with 90 per cent of those who used the service reporting feeling 'better' or 'much better'. Speaking with one of the volunteers about the telephone counselling service however portrayed a more ambiguous story of success. The service provided a limit of six sessions of telephone counselling. I asked the volunteer, Jane, whether

she thought six sessions was enough time to see any improvement. Jane hesitated before telling me that in some people she did see some changes, but with others there was no change at all. Jane further suggested it could make things worse. Six sessions wasn't enough time to "bring up" all the emotions and then work through them effectively. Clients could be left with more 'unresolved problems' than they started off with.

Data from bereavement counsellors and support workers did not provide a unified vision of what recovery looked like. Participants described the processing of finishing with a client as a "long process" that involved "constant reviewing". Caris counsellor Claire described it as "very sort of drip, drip, drip" and "not anything like a clear road". Many counsellors and support workers described a mutual intuitive sense of knowing when the "work is done" and "it's time to say goodbye" by a change in the "feel" of the counsellor-client relationship.

There were, however, markers that practitioners observed and looked for to know when the "work was done". These involved recognising that the client was taking an interest in their own life again and had started talking more about her or himself than the person they had lost. It could also be evidenced by practical things such as thinking about going back to work, taking up hobbies, doing new things, and meeting people. These new activities were often described as ways of internalising the lost person into the client's new life, as Daniela (BC3) explained:

So people look for ways to keep the deceased in their life but in a way, which allows them to live. So you might find the some people take up hobbies which remind them of the lost person which then gets them into a place where

they're meeting people and doing new things but they are also internalising the person that they've lost through this new activity, because maybe it's rock climbing or singing or salsa dancing and the person that they've lost was into that.

What was being described was thus a shift in the client's identity that allowed them to have or rediscover choices via a "loosening" of the grip of grief. Counsellors and support workers observed how a client's identity could transform in the counselling encounter to inhabit a different sense of self.

My participants often drew on particular cases to elucidate their ideas, avoiding generalisations where possible, and emphasising the individual context. Further, they appreciated that ways to recovery were individual and idiosyncratic and there was not a 'normal' way. In the person-centred approach the client was the only expert on what was appropriate grieving behaviour for them, as Wendy (BC1) explained:

If a client is going to the grave every day and happy to do that and finding it supportive and not intrusive, then good for you and who cares if you do that for the rest of your life if that's good for you. But you might get another client who feels that going every fortnight is too much and is getting in the way and they can't stop themselves and they feel like it's unhelpful and so, who can decide what's normal and not normal, only the client can.

As argued above, the components of normalisation and safety were key in tailoring an individual specific recovery. At the same time there was acknowledgment that societal norms had levels of restriction on expressions of grief and recovery, and

permitted certain behaviours over others. Recognising the normative requirements on emotional expression, Daniela described the process of recovery as “a really difficult dance to do” one which “nobody knows what the steps are, nobody knows what the bloody music is”. For her, and the other counsellors, the counselling setting was an opportunity to experiment with revealing thoughts and feelings not permitted elsewhere.

My data show some agreement over recovery as being a sense of “moving forward”. Movement and stuckness were key terms used by all participants, implying the natural process of grief. Recovery-orientated activities, such as letting go of the deceased person, were largely viewed as a conscious decision, a choice that was fostered by the building of “ego strength” experienced through the counselling process. On occasion Freudian terms were employed to identify this movement as a “reinvestment in energy” from mourning the person who had died back to the client’s self (or ego), as Linda (BC2) explained:

(...) what we’re hoping at the end of counselling they’ll be more forward-thinking. Because the process of grief means when somebody works their way through it then they’re able to reinvest all that energy that they spend in grieving and need to, but then they start to withdraw that energy from that grief and for the mourning of that person and they start to reinvest that energy in themselves.

This enabled clients to become “forward-thinking” and think about the future, moving away from the past and into something new. The future was depicted in contrast to the “nothingness” of grief, but there was not always a clear vision of what lay beyond.

For Claire (BC5) it was just “a different place” beyond the “period of nothingness”.

However, in the Grief Recovery Method that sets out a clear path to recovery through their method of ‘completion’ there is no scope for ambiguity. Completion is gained through the writing of a letter that has a very specific format, as presented below:

Dear.... I have been reviewing our relationship and found some things that I want to say...

I apologise for...

I forgive you for...

I want you to know (significant emotional statement)

The letter was written to the person with whom clients wanted to get ‘complete’, to rid any ‘unresolved communications’ they might have. The letter had to be ended properly by writing ‘goodbye’ to complete the communication. Not saying goodbye risked leaving someone incomplete. The letter then had to be read in front of another person in order to become complete. At the workshop when some of the group members questioned why the completion letter had to be heard by another living person we were told: “I don’t know, it just works”. In our interview, Ellen further explained that they had found through testing that reading the letter to the air or a mirror or a grave didn’t work. During my attendance at the workshop, I struggled to identify in the explanation of completion what precisely was special about the method. I wrote in my fieldwork diary how completion was positioned like a ‘magic wand’:

Completion was described in such a way it felt like a magic wand. And the

method was so all encompassing – it heals every type of loss! It was as though it could do anything. It was the only answer. Ellen was evangelical about its virtues. (Fieldwork diary, September 2014)

When I asked Ellen whether there might be other ways to get complete, she permitted that maybe there were, but then stated she might have thought the same before she knew what completion meant. In the GRM then recovery can only be achieved through a specific activity without which people are incomplete. Yet even completion does not provide the permanent recovery it promises. Completion letters could be written a number of times to the same person. Ellen described how she needed to get complete again with her father, revealed when she started to cry at the workshop. “There’s some more stuff I’ve got to get complete with, that’s why I started crying”. I asked Ellen in our second interview whether completion was then a temporary thing. “Inevitably it almost is”, replied Ellen, “But you can be as complete as possible”. The purpose of ‘getting complete’ was to communicate all the ‘unsaid’ things you needed to say. Yet even for Ellen, new thoughts and feelings emerged that needed communicating, and so completion became an ongoing process. The act of completion was emphasised as crucial but it was a misleading term to describe a process that did not appear to have an end point.

Thus, recovery emerged through the frameworks and models and literature and methods as a contested site with boundaries never quite defined. Recovery in one’s life becomes an ongoing project only glimpsed at for a period in the counselling encounter. The GRM’s promise of completion is flawed as Ellen acknowledged that completion can only last temporarily. Recovery and completion are forms of work carried out in the promise of self-integration and eradication of ‘incomplete

communications.’ However it is possible to wonder, as I did at the end of the Grief Recovery workshop, what might be so wrong about being incomplete. Yet ‘incompletion’ is not a desirable option when at the heart of the theory is the belief in an autonomous self-contained subject with conscious control over choices. Incompletion is a threat to the continuity of this sense of stable personhood and one that risks disintegration.

6.4.2 Resisting recovery

This same understanding of the subject is at play in the judgment of those who fail to recover, formed in the shadow of human potential by which all come to be measured. Largely, the bereavement counsellors and support workers interpreted failing to recover as a form of resistance to accepting the reality of the bereavement, or as a resistance to the method. Resistance could be identified by practitioners in a number of external displays of client behaviour but also through the avoidance of, or incorrectly performed, internal emotion work. My data show that resisting recovery was explained more commonly through reference to “stuckness” or “getting stuck”. As discussed above, moving forward and stuckness are the metaphors of choice when grief is understood and agreed as a process with a start and finish. Stuckness was easier to identify when framed by the assumption of time-limited grieving and the expectations that accompany the ‘normal process’ of grief. As Daniela (BC3) explained in response to my question: how do you know when someone is stuck?

When its two and a half years later and they still cry at the mention of someone's, the person's name. When it's a year and a half later and they still have got all their clothes, when they can't say that the person is dead, when

they still talk as if the person is alive.

My data show that stuckness was signalled by a lack of movement or even a movement backwards. Stuckness was becoming “fixated”, “immersed” and “overwhelmed” by negative and unhelpful thoughts. Stuckness showed itself in a variety of different behaviours, some of which as Cruse support worker Susan described were “easy to judge”. These could include deterioration in general appearance and hygiene, disrupted eating and sleeping patterns, and substance abuse. Susan also used worksheets to help her identify when clients were not functioning at a reasonable level: deviant behaviours were marked by a shift from green to amber to “red alert”. Other interpretations were less clear-cut but still common themes emerged in the practitioners’ understanding of stuckness. For Susan (BSW1) some types of bereavement could “predispose” people to having complications in their grieving:

There’s certain types of death that pretty much, they predispose someone to the likelihood of it's not going to be easy. If it's a murder or an accident, road traffic accident something sudden, something traumatic.

The EIP, described in Section 6.3.3, also highlighted pointers that could put people at risk of developing complicated grief, including being bereaved by a sudden death. Regardless of the type of bereavement, in general my data revealed that unwillingness was the popular explanation for why people got stuck and failed to progress in their grief. In this unwillingness people actively “bury feelings” and fail to “open up”. There is an inability to accept the death and they “don't seem to be willing” to go back to work, or return to the “normal world” outside the “grief bubble”. This

'hermit group of mourners' (Jordan & Neimeyer, 2003) also remains resistant to the counselling method, a resistance that counsellors and support workers interpreted from the cancelling of or turning up late to sessions, or in how clients might save talking about "real" feelings to the end of a session. Some participants would speak of the unconscious nature of this resistance that drives particular behaviours such as forgetting to turn up for a session. According to Wendy the client was unconsciously finding ways to keep away from the painful reality of loss. Wendy (BC1) described how behaviours could be read to understand the unconscious:

People who turn up for their appointments an hour early, even though they've been coming for a year at 11 they turn up at 10. Why do they do that? Because their unconscious was saying I really need to get there. Or people who forget their appointment even though they've been coming for a year at the same time, because their unconscious is saying we're not doing that this week. Quite often you have to look at behaviour and that gives some idea of what's going on unconsciously.

In other interpretations stuckness and resistance were simply being "unprepared to change". In the GRM this was due to a rigid belief system and old ideas that encouraged people to "push down" their grief. For Ellen stuckness could only be understood as the inability to "carry out the steps" for, as she declared, the GRM "can help almost anybody". In this thinking, the failure to recover will always be due to a lack of adherence to the method, and thus a failure of individual choice, as stated clearly by GRM Director Ellen:

Because I haven't seen the method fail. I have seen people fail the method.

While it was not so black and white for the other participants the reality of people getting stuck in grief was certainly acknowledged. This was partly attributed by some of the practitioners to the fact that a certain level of stuckness was what made a client eligible for counselling initially. For the most part stuckness was something that could be moved out of provided the client made the right choice and showed willingness for the method. However, there were admissions that some people could only be “taken so far” or, as mentioned above, some people were considered “predisposed” to complications. People could be separated into three categories of response according to Ellen:

So some people will never recover. Some people will bury it deep and act recovered. And it only needs the next knock and it can smash it all to pieces. And some people fully recover, and I would say I'm about as recovered as it's possible to get.

Arguably in the GRM everyone was stuck if they hadn't encountered or succeeded with the method. This point of view is a several-layered judgment that crucially presumes recovery, and its failure, are assessable by the monitoring of behaviours. For recovery can also be an 'act' or 'performance' put on when grieving feelings had not been adequately worked through. Resistance to the method and resistance to personal change, read from the point of view of the expert becomes the same thing when the method proposed is considered as the only reasonable means to gaining self-fulfilment. Resistance then is not only a disagreement with counselling or the *Grief Recovery Handbook* but a resistance to all the things that recovery, completion, and integration encompass. Failing to recover in these terms is thus a rejection of flourishing, choice, and congruence in self-concept, and of hope, the future and its

potential.

6.5 Conclusion

In this chapter I have highlighted some of the components of bereavement support, largely in the format of bereavement counselling, and how such support seeks to aid recovery from grief. From my data, I have revealed the nuances, conflicts and ambiguities in bereavement counselling, and how the therapeutic response is not merely disciplinary but a productive encounter. As elucidated in the work of Arnason (1998; 2001; 2007), bereavement counselling is a productive rather than repressive setting, where identities are crafted as a co-production. I have drawn attention to the context of bereavement support in the UK and the at times inconsistent training in and delivery of bereavement care. As Hockey and Small (2001) have discussed, within bereavement counselling there appears a proliferation of specialisms but a marginalisation from the mainstream. This might be due to the nature of bereavement that does not favour brief time-limited therapies such as cognitive behavioural therapy more commonly used in mental health care services, to manage conditions such as depression. Bereavement counselling and its person-centred focus remains little changed and for the most part unaware of the developments in the grief and bereavement research literature. This is, perhaps, a result of the emphasis on grief as 'normal' and 'natural' and a subsequent shying away from any forms of 'medicalising' grief. Yet it also indicative of the gap between bereavement care practice and the implementation of empirical evidence.

It is unanimously agreed, however, that grief requires work and is helped by expert

intervention: an unsurprising view for those that are invested in the field of bereavement support. This is reflected in the quantity of bereavement counsellors and support workers that explain the value of their role in reference to their own loss experience. It could be said that becoming a counsellor is part of the recovery of the counsellor. The value of counselling work, and talking through emotions or following the steps in the *Grief Recovery Handbook* are without question considered the most effective means to relieving the pain and suffering of grief. In this framing recovery and non-recovery emerge as an unwillingness or inability to do the work. Describing grief as 'work' is not an accidental metaphor, for the process involves a meticulous labour both within the psyche and in the social relational life of the person.

I argue grief work is a technology of the self that is gladly undertaken by the client, for the intervention has been rationalised in terms of individual freedom and happiness. In Chapter 5, I discussed the ways in which contemporary government had become invested in individual happiness and wellbeing, where recovery from unhappiness had political and economic benefits. Bereavement care too is increasingly framed as reducing the 'burden' of bereavement and preventing the 'risks' of complicated grieving. In the counselling setting the move towards recovery becomes an ethical rather than political goal phrased in notions of potential and the freeing and fulfilment of the self through making the right choices. In this way, as Rose (1997) argued, psychological expertise becomes a 'relay' between government and individual private lives, where public values are bound to private authorities.

Here I argue that counselling becomes an arena for the crafting of the self with the intention to bring one's identity more in line with one's true nature. Evolving into one's true nature my data showed, clearly had its limits and what constituted self-

fulfilment and the 'good life' were demarcated by the behaviours and activities that were read as problematic and getting stuck. What constituted recovery was not always made clear and some practitioners insisted that they did not have an agenda or goal in mind when dealing with a client. However, the investment in the notions of individual choice, autonomy, self-awareness and forming a coherent identity are clearly tied to the achievement of recovery or integration. These features were considered an unquestionable good. Governing individuals in terms of their freedom, however, presents an ethical obligation to the client, which makes the stakes of refusal all the greater. Refusing to recover in such a way may condemn someone to never recovering or to a performance of recovery that sooner or later will falter and for grief to come back to bite. It also ignores the way in which counselling is implicated in the construction of the social realities to which it seeks to adjust its clients (Árnason, 2007).

Resisting recovery and failing to recover, is framed not only as a failure of moral will but also a resistance of one's true potential. And yet the promise of recovery as revealed in the GRM's notion of completion is inevitably a temporary one that requires continual work to maintain. Recovery is thus the constant horizon of potential, both motivator and cruel promise, but never quite reached. In this way, the methods and models developed to guarantee recovery are always in demand when the journey to recovery rarely meets its summit and work of the griever seldom ceases.

In the next chapter I enter the world of the client and the forms of 'grief work' the bereaved person might undertake to manage their grief; forms of grief work that complement and diverge from the guidelines maintained by those who seek to help

the bereaved person navigate their way through the liminal space of grief.

CHAPTER 7

Navigating the liminal space of grief: Making the journey

7.1 *Introduction to the chapter*

In this chapter I present the accounts of those negotiating the liminal space of grief by exploring three themes of the data: how the participants made sense of their experiences, how grief is performed in everyday spaces, and the types of identities participants came to inhabit. I view these three themes as interwoven, for instance, how participants make sense of their grief has implications for the type of identity they might come to inhabit. Yet meanings and identities are entwined with the materiality of everyday life where they are acted out, performed and embodied.

First, I address how bereaved participants in this study made sense of the experience of grief. I begin by exploring how participants retold the story of the death of their partner or family member and what explanations - both rational and symbolic - they drew on to make sense of their experiences. In their accounts participants included descriptions of events and activities and also emotions and metaphors. Telling stories and giving voice to one's pain is a commonly accepted tool to provide liberation from suffering and oppression (Charmaz, 1999; Charon, 2001; Smith & Sparkes, 2008). Yet, as I argue, not all stories get to be heard and the act of storytelling reduces the forms of expression into 'standard' narratives, excluding those unable to articulate their stories. In the second section, I highlight how participants made sense of grief in their everyday lives through practical activities that enabled them to negotiate the changing material space around them. 'Grief work' in this sense was not necessarily

psychological and intellectual work but about managing material spaces and objects and structuring a daily routine through actions.

Third, I explore the identities that participants came to inhabit. Participants either claimed an identity in their interview accounts or described how they felt others attributed a particular identity to them. These identities were new and changed but also old identities were maintained by keeping ties to the deceased person, and I illustrate some of the ways in which participants continued bonds. Following the frameworks of recovery described in Chapter 6, I consider how some forms of relating to the deceased person are considered part of recovery yet others are considered as resistant to it. I take a closer look at the 'resistant' identities that emerged and ask how resistance can be read when the narrator does not identify with the notions of recovery or non-recovery.

7.2 *Making sense of grief*

7.2.1 Rational and symbolic explanations

Many of the participants in their interview accounts addressed three key areas: the process of a partner or family member dying, the event of the death, and the subsequent response to the death and feelings of grief. Following the setting up of the scene of a death participants continued to describe events that happened after the death and which were interspersed with their own feelings and often biographical information about themselves, their partner or family member that died and even other family members and friends. In line with Árnason's (2000) discovery, I argue the participants were constructing not so much a 'durable biography' of the deceased

person, argued by Walter (1996), but a story of themselves and their relationship with their deceased partner or family member. I found that participants would organise their accounts with a mixture of rational and symbolic explanations. On the one hand there was a need to confirm the truth of what happened when the person died, and yet on the other hand participants referred to signs and metaphors to help them make sense of the death and their feelings of grief.

Most participants narrated their experiences using this structure with little prompting from me. I would begin the interview with a question that referred to a detail the participants would share with me prior to the interview, such as, "You mentioned your husband died four years ago?". This lead in the majority of cases to a description of the death; for example, Laura relayed to me how her husband died in this way:

He needed his medication so the two paramedics took him into the ambulance (...) when I came down the ambulance was closed up and rocking and it was at that point he'd collapsed and he had, it turned out, a ruptured aorta (...) Very traumatic. Massive shock. Went into shock for I would say six months. I functioned, I went, I was back at work, because we buried him, well cremated him on 6th January and he died on 22nd December.

The participants followed a largely chronological order starting with the story of the death and for some, the illness that may have preceded it. Rose, for example, wrote me a timeline of her life with her husband, that she emailed to me prior to our interview. "A compressed history" she described it, which presented a chronology from when they met up to the year of his death. This sense of a need to be thorough in

their accounts was common. At the close of the interview, Anne reached for some notes she had written beforehand to ensure she had told me all the details. For Anne, the death of her husband became a matter for a police investigation, of which she spoke at length. The question over the cause of her husband's death propelled Anne into a search for the true sequence of events as she explained:

He fell out of an office window. It was an accident. That's what happened. He was closing it, and he fell four floors (...) Now in fact what happened was he had fallen out of window, at his work, at quarter to seven at night. Now I know it was June, but I was busy thinking the high street in (place name anonymised). Your head - in the absence of information your head grabs at anything it possibly can to make it work, to make sense.

Following the death of her husband, Anne described the task of reconciling what she thought to be true about her husband with the alternative options suggested by the police investigation. In this excerpt from Anne's account it is possible to see how important it was for Anne to locate the story in time and place, as well to clarify the truth of what "in fact" happened. In both Anne and Laura's accounts, there was a reliance on - or need for - the 'truth' where the emphasis was on the maintaining the accuracy of the date, time and sequence of events.

However, participants also readily drew on more symbolic means of making sense of death. For example Rose, whose husband died 26 years prior to the interview, narrated the account of his death by drawing on signs and symbolic references:

37, both of us were 37. He was born on a Saturday died on a Saturday. Born

on third of the month, died on the third of the month. Born at 4.30, died at 4.30. And I even added to that, he was breech birth and the first thing I saw when I was coming down the stairs was his feet (...) [W]hen we swapped the house and when we moved in, there was this vase of flowers on the table, now I don't know if you know of the, there's a superstition do not have lilac in the house because they'll be a death in the family, but there was lilac in this arrangement and I remember saying oh we shouldn't have, but I adore lilac so I left it and we got home and he died, there's a death in the family. It's not logical but you can't help but sort of go, it's weird.

Like Anne and Laura, Rose focussed on the details surrounding the death, which she recalled even 26 years later. Yet this emphasis on the factual detail was given a symbolic meaning, so that in her narration Rose's husband's death appeared somewhat fated. In her description, Rose highlighted details such as the lilac in the house and endowed the superstition with meaning, even as she acknowledged, "it's not logical". 'Signs' from Rose's husband were present too after his death, and as I discuss later, her husband's presence remained very much alive in Rose's life.

While understanding and knowing the 'truth' of what happened was one part of the process of being able to narrate the story of bereavement and grief, it appeared that describing the internal experience of grief within a rational framework posed difficulties. Participants remarked that they found it hard to describe the feeling of loss, saying how "complex", "ethereal" and difficult to "quantify" grief was. Participants, therefore, often drew on metaphors to describe their feelings. Grief was described as a place of darkness where the "light had gone out", feelings felt "dark" and "black" and it was a place that people would move "down" into. Spatial

metaphors were present as Laura described widowhood as a “very strange land” with “no map”. Anne too explained her experience of navigating grief as being lost at sea:

I needed to try something, to catch at some sort of straw because I did feel like a little rubber duck in the most amazing storm at sea, no land, no light, just waves and lightning and thunder and no shore.

While grief was described as a place in which the participants had unwillingly entered, the individual bodily effects of grief were described as physical pain. For example, the pain of grief was described using physical descriptors such as “spiky” and “stabbing” and “raw”. Anne detailed in visual terms the experience of grief and how she once thought it was just a “metaphor” but discovered the bodily ‘affects’ of grief:

I always thought that was a metaphor, it's not, it's physical. My whole body cavity just screamed in pain and even now, when I'm stressed, my sternum feels like all my tendons are pulling off it physically. I just had to this view of the inside of my body being this black and splattered cavity where my heart and soul had just splattered into a million soggy, pieces. And there's an awful lot of, trying to stick pieces back together, and it's still a right old mess.

The almost violent imagery conjured up by Anne portrayed a vivid picture of the embodied experience of grief. In the interview Anne drew on metaphors quite often to describe her feelings, acknowledging that she liked to use metaphors. However, I suspected that not all participants were as able to convey the embodied experience of grief through language, moreover in an interview setting. In Chapter 6, I described the

importance of safety the bereavement counsellors and support workers emphasised in the counselling setting, where the client was made to feel they were in a relationship that could hold the 'unbearable' pain of grief. When participants would state things such as: "It's just awful" or "the worst experience of my life" I imagined they were referencing this 'unbearable' pain that was hard to quantify and articulate. Further, this was a pain the participants described as embodied, evidenced in a physical impact on body causing symptoms such as sleeplessness, difficulty eating or as Anne described, a pain located around the sternum.

Therefore, I argue the use of metaphors was one strategy that enabled participants to convey the experience of grief; yet there could be a limit to how much meaning could be made from the experience of grief. In Chapter 8, I discuss further the limits of language (and my chosen method of interviews) in expressing the 'unbearable' physical and emotional pain of grief. While the participants would narrate what had happened, they also remarked how they had not quite understood what had happened. As John remarked over his wife's death:

Still can't understand why it's all happened, I still don't. I find it difficult to accept it, you know, when I'm daydreaming in a way. It's only when I think to myself, come out, snap out of it.

Speaking about the sudden death of her husband Tania told me:

Yeah it's a bit strange. I sometimes think now did all that actually really happen?

Listening to the participants' accounts of grief it was as though the rational - or at least those explanations that were available - had reached their limit when it came to explaining the event of bereavement. Therefore, participants would use rational and symbolic explanations interchangeably, as demonstrated by Rose's statement above "it's not logical but". For Anne it was the nature of her husband's death for which she struggled to find any meaning:

It just doesn't make sense and, it shouldn't happen. We're in a first world country, we can do all sorts of things and yet we can't keep people safe in office buildings (...) I never imagined that he wouldn't make it out the front door of the office.

As Anne highlighted, the death of her husband felt nonsensical in a "first world country" where she felt accustomed to the idea that she and the people around her were relatively safe from immediate threats to life (at least in office buildings). The experience of her husband's death thus challenged Anne's whole belief system, her sense of ontological security. Anne went on to explain how she had lost her faith as a result, unable to 'compute' the death of her husband:

The thing is through this process, well, I lost all my faith. The point is whether you suddenly start seeing signs in everything that drops from the clouds or every rainbow, you either go one way or the other. You either talk about people looking down from heaven and meeting you again or you say no-one could allow that to happen it can't be (...) And there is, even four years later I can say to myself what? How on earth? That can't be right, that does not compute.

Anne's 'assumptive world' (Parkes, 1972) following the death of her husband, had been transformed. Anne was then left to search for a new sense of meaning. In doing so, Anne referenced the use of signs and heaven that she acknowledged other people might use to make sense of death, but found them unsatisfactory. Yet Anne still relied on some wider meaning to the universe even as she described she no longer believed in the idea of God:

(...) and it was why me? That's not supposed to happen. I've always been as nice as I possibly could be, kind. I was dealing with all this anger with God until I realised he wasn't there (...)

Instead Anne found some meaning in the idea of 'multiverses', which enabled her to believe the energy and soul of her husband was not destroyed but potentially existing in another dimension.

In this section I have shown how participants strove to narrate a chronological and comprehensive story of the death and the character of their partner or family member, including fine details of dates and events. However, this need to convey the truth of what happened was mixed with references to signs and symbols that participants also used to make sense of death and grief. While most of the participants competently narrated their stories to me by drawing on narrative features such as plot, characters, and metaphor, finding meaning in their experiences was a different activity to telling a story about it.

Despite the individuality of grief, it was interesting to see how the narration of the experience of grief was situated in relatively limited 'domains'. Rosenblatt (2000) in

his study of parents' narratives of grief found that what the parents talked about fell within a limited number of domains including the moment of death and events following the death and finding meaning and managing feelings. Participants did find various meanings some of which I have described above, for example, Rose's signs and superstitions and Anne finding comfort in science and multiverses. However, in the next section I want to draw further attention to this struggle to piece together a satisfactory story through the account of John, to consider the effects of being unable to find the right story.

7.2.2 Failing to make sense of grief

What struck me about John's account was his need to find the coherence in what happened and the struggle he encountered in living in the face of incoherence. Rather than viewing this necessarily as a biological need to narrate, I suggest the focus on certain standard narrative forms in western cultures only compounds the events that fall outside of this pattern, fostering a need to assimilate them. Here I present John's search for coherence and his need to find a satisfactory line of reasoning for his wife's death. John's wife died after a short period of illness of terminal cancer. Due to the speed of events, John found it was six months after her death, at the point of interview, that he was going over the details of the death and questioning things:

I'm finding it harder to accept that than I did straightaway. But it was very quick, it was literally from October, 30th October to the 5th March so it was, barely four months (...) and I just feel that it's hard that someone who's looked after herself so well, she didn't smoke, hardly drank, kept herself fit, ate the right things and wallop done completely, completely wiped out in four

months.

John highlighted details about his wife's lifestyle such as being fit, eating well and being a non-smoker that did not fit with the broader narrative of dying of cancer. John reflected on the things his wife could have done differently saying he felt "let down" that, as a practice nurse, she failed to look after herself like her patients. In retrospect, John could see the signs of his wife's stomach pain and how they "missed" them. He described how now he had the urge to go over the details of his wife's death to solve the puzzle of why she died:

I keep on looking at it from the point of view that we should've been able to see it coming you know. There should have been some indication that, what did we miss, what did I miss, what did my wife miss (...) And I kept everything at home, I've kept all the paperwork and we tried to make notes about what people were telling us. (...) I did think about trying to write it all down and try to do some sort of putting it all in chronological order and try to make some sense of it all, but I don't suppose. At other times I think to myself well would that do me any good in a way, would it just all bring it to, bring it up again and then I'd be left with, what would I do with it then you know. So it's a bit of a conundrum really.

John appeared to oscillate between the two plans of action: to sit down and make sense of it or to accept he could not do anything about it. It was clear though, evidenced by his wrestling over this conundrum that living with uncertainty was not a comfortable place to be. I asked John how it felt to potentially live with and accept things might not be resolved, he replied:

Well, well I'd rather be clear in my mind that where things stood, well you know what the problem was, how it came to be, all those issues but I just think they're all, well a lot of them are beyond, beyond resolving in effect. You can't do that now. So I'm just, it's something that I'm pretty certain that I'm just going to have to live with really. Have to sort of say well that's it I just can't take that any further and sort of try and get on with life.

Without an acceptable story of what happened John found he was lacking a resolution that had forced him into what I have called a (liminal) space where it was not clear where "things stood". In this liminal space, as John ruminated on his recent past, he was unable to go forward and "get on with life". He explained how without this resolution about what had happened he could not make sense of the present or the future:

It's when you start looking back isn't when you, you can put some sort of picture to it all and I think that's probably one of the problems at that moment is that I can't do that. Because my life has changed so much with my wife passing away that until I've got a little bit of history that I can look back on and sort of judge where I am at that, whatever, time. Whereas at the moment I can't do that.

I argue that the absence of a "little bit of history" meant John could not locate himself in the present and make sense of his life without his wife. Living with unanswered questions John was left with a tenuous attachment to the present where, on the one hand he recognised he had to just accept and live with it and yet, on the other, the

desire to know and make sense remained strong. This sense of ambivalence however was not easy to overcome. John acknowledged the only resolution was then to settle for the absence of an answer:

And I suppose I'll have to get over that because there's no way round it, I can't, I don't, it'll never be solved that question, I'm never going to resolve it, it's just a feeling I've got and I'm going to have to live with it. Can't, I can't, no-one's going to say, no-one's going to come up with an answer to that problem, I'm just going to have to accept that it's happened and just get on with it really. Hard. Very hard.

It seemed that not having a coherent story placed John outside linear time where he could not rely on a past and a history that made sense from which to locate himself in the present. Instead, John was in a cyclical mode of time, taking each day as it came. This was the only way to manage living on where the past was unclear and the future was uncertain. Without a story, settling for uncertainty and liminality was the only option. Crafting a clear story about the death was one mode of bringing coherence and understanding to an incomprehensible event. However, the focus on narratives hides the struggle to find a story as described through the account of John, and also disadvantages those that lack the language, ability or desire to construct a narrative and allow it to be heard. Living outside of this linear narrative structure meant the need to build familiar structures in daily life through routine and physical activities became increasingly important, as I describe next.

7.3 *Affective practices and recovery work*

Here, I discuss the practical forms of activity participants described following the death of their partner or family member. Participants described a changed world where the time and space they inhabited had transformed. Participants described feeling as if they were in a world where everything was “black” without a map or guide to help them through. I argue that, in such a liminal space the boundaries between appropriate and inappropriate behaviours dissolved: Laura, for example, described this as “widow brain” that felt “like having cheese in your head”: activities that were once habitual to her, such as reading, she no longer had the ability to do since her husband died. In such a state, while Laura found she lost the ability to do certain things, it also provided the opportunity to achieve feats that previously she would never have considered. Laura impulsively bought a piano four months after her husband died despite being tone deaf. Anne, too, described her brain as “turned to Swiss cheese” where “time stops being chronological”.

This fostered a need to “do something” from undertaking more conventional forms of ‘grief work’ such as professional counselling to finding new purpose in everyday and mundane activities. Participants described the interaction with space and objects, as well as the ritualisation of the everyday, as strategies that enabled them to carry on living. In this liminal space, being busy in the present helped to locate a self where the past was difficult to narrate and the future had been lost. Planning a daily routine became necessary to give some meaning to an existence lacking in sense, a meaning that was upheld by a person that had now gone.

7.3.1 Rituals

Following on from my discussion in Chapter 3, I argue my data show the 'affective practices' employed could be 'formal' rituals or routine everyday activities that took on a new purpose in grief. Shortly following the death, participants described a flurry of activity. Saadhia described the preparations she had to make following her mother's death:

I was like in a daze and then I thought right I need to get her, pick up her shroud, I've gotta get this, I've got to get the house sorted because there'll be lots of people coming over to pray. I need to rearrange the furniture, I need to make sure there's lots of food, because my Mum would never let anyone leave until they've eaten when they've come to our house. I wanted to do all those things right because that's what my Mum would have wanted. So I fell into this whole sort of roboty thing (...) and it was like I was some kind of robot. Like Mum's coming home.

This feeling of being on "autopilot" was described by many of the participants, where physically doing things was emphasised as a way to ward off or manage overwhelming feelings. This sense of autopilot was described by Saadhia as a "need" – and almost as an obligation - to carry on and function, both to ensure she did as her Mum would have wanted but also to help others around her and as a form of self-protection. Saadhia also had more formal rituals to fulfil following Islamic tradition:

(...) we were going to the mosque and she's there ready to have her wash and I couldn't wash her because you're not allowed if a woman's menstruating,

you're not allowed to touch the deceased. So I gave all my kisses and hugs and everything before everyone else took over, and I just watched from a distance. (...) I had to close her eyes and cover her head, take all her jewellery off and straighten her hands and legs. It was stuff I'd read, Islamically, what we're supposed to do when someone passes away. So whatever I studied I tried to do it practically because I wanted everything to be perfect for my Mum.

Islamic tradition gave Saadhia clear rules to follow, with practical guidelines in her “robot”-like state. However, Saadhia’s account was the only one among my data that included specific religious rituals surrounding the disposal of the body. These rituals aided in the management of the disposal of the body, which, to an extent, enabled Saadhia to mark her mother’s death, yet she found when dealing with grief she was left with no rituals to follow.

Therefore, my data show a distinction in the participants’ accounts between rituals concerning the management of the disposal of the body, which were already prescribed by the cultural tradition, and the management of grief, which had a less clear route to follow. Other participants mentioned arranging and attending funeral ceremonies but focused far more on the management of their emotions looking for direction from contemporary psychology and therapy in the form of bereavement counselling and support groups. Both Tania and Laura described positive experiences with Cruse and three of the participants I interviewed had been involved with Widowed and Young (WAY), a peer support group for women and men whose partner died before age the age of 50. WAY arranged trips for their members as well as having a popular online presence. Laura, Tania and Anne described how WAY and

the forum Merry Widows¹⁸ had provided them with an unconditional support from people who just “get it”. The women described the “immense relief” this provided where “no explanation needed”. For each of the women WAY and Merry Widows helped normalise their grief and also provided some support where they felt there was none to be found. Peer support and becoming a member of a group was a useful strategy for some but for John attending a grief support group only highlighted the individual nature of grief rather than its commonality. For John the emphasis on grief as an individual experience meant that although it normalised the feelings of grief to an extent, to know other people were going through the “same grief”, it also separated him from others and forced him to realise there was not going to be a “quick solution to it all”.

My data show that, in the absence of traditional rituals, there was an assumption that certain activities would be helpful for grief, though these could expand beyond the conventional. Tania provided a list of the activities she had undertaken, from counselling and the Merry Widows forum to books and reiki in her desire to “get fixed”:

I needed to get it fixed, I needed to I needed to be okay. (...) I did all the reading, I read millions of bereavement books, the Elizabeth Kubler, didn't get on with her at all, the seven steps to grieving I was just like that's not for me at all (...) I saw a medium twice, which was a bit bizarre, because I'm not really the type of person to see a medium or a spiritual person at all, never believed in any of that, but after six months I felt the need to go (...) I don't think there's anything I haven't tried. Yeah I tried the crystals, yeah I still

¹⁸ The Merry Widows website: <http://www.merrywidow.me.uk/> (Accessed 6 June 2016)

sleep with crystals beside my bed I don't know if it helps at all, reiki which didn't really do anything, pretty much spent a fortune on everything going (...) I think I was trying to get it all done at once (...) I was a bit of a woman possessed really. I'd got a whole bookcase of grief books.

For Tania the need to be doing was strong, whether or not it helped or she “believed in any of that”. As she described, she was “a women possessed”, getting “it all done at once”. By maintaining the belief that grief was something that could be eradicated by specific activities, Tania adopted an approach of trying everything available in order to get “fixed” quicker. Tania’s search for something that would enable her to “get fixed” could be understood as an example of the obligation to recover, where Tania reached for some of the available tools society was providing her: grief books, mediums and crystals. The pressure to recover might be one impetus to undertake various activities. But as Anne described, grief produced a great amount of energy, which propelled her to get things done:

I call it terrible energy, because it is terrible, you cannot sit still, you've got to drive and do things all the time, because as soon as you stop, it just, it's like out running a tidal wave. And I have to run and run and run.

As Anne described it, the energy she experienced, similar to Tania’s sense of feeling “possessed” to get fixed, was not quite in her control. It was the stopping or sitting still that both were striving to avoid, and yet they failed to describe exactly what it was they were seeking to run away from. However, how energy was used and consumed was interpreted differently. As described in Chapter 6, the Director of Grief Recovery UK called activities that bereaved people tend to engage in as ‘short-term

energy relieving behaviours'. For example, eating too much or shopping or gambling were time fillers and a "distraction of energy" that "relieve the energy, but they don't heal you". This was a trope common in the understanding of grief work, where grief had to be dealt with successfully via certain methods else it would come back to "bite" years later. Distractions and relieving energies were only a way to help keep the tidal wave at bay for a little longer, a wave that would, according to dominant understandings of grief, overwhelm you at some point. However, I argue that these activities, whether formal or informal rituals, were central to the management of grief and the management of self-identity. In the next section, I focus on activities that would be considered 'distractions' or 'energy relieving behaviours' in the GRM, and how the participants described the important role they had in helping them through the liminal space of grief.

7.3.2 Distractions

As Hockey et al. (2005) identified, the practical aspects of everyday living such as shopping, socializing and cooking were intimately bound up with the 'emotional transition of bereavement' (p. 136). Thus, household and intimate work took on particular importance in those accounts of participants, particularly John and Paul, who were in retirement. The shift in daily routine was also amplified for those who had been long-term carers for their partners or parent before they had died. Paul and Saadhia had both left their employment to take over caring responsibilities. They both described how their daily routine was intimately entwined with another person. The absence of that person highlighted how much space had been occupied by the work of caring and how the days were timetabled with activities, as Paul described:

[Y]ou get a closer bond so it was even more, probably even more painful because it, the routine you had, getting up and doing things and looking after them and making sure this and doing some washing every day and washing her and cleaning up and making sure she's okay and using the commode, clearing that up multiple times a day and doing this and doing that you know it's (sighs). And then when that's not there (...)

In a similar way following the death of her mother Saadhia explained:

And it was, when you get yourself into this routine and timetable, and then you hear the voices. I hear her calling me, she used to always say: 'Saadhia, Saadhia!'

For Paul and Saadhia being a carer provided a centre around which their life had revolved. The loss of the person they cared for daily made the absence all the more acute. For all participants, including those that were not carers, there was a feeling that the centre of their life was lost and with it the "incentive" or "motivation" to carry on living. Paul described how his dogs created a routine in the absence of an incentive, where he felt following the death of his wife he had nothing to do:

Even now I haven't got an awful lot of incentive, I make myself, I make myself get up in the morning have a little bit of a routine, basically because of the dogs to be honest (...) so I have to get up and I get up at a certain time and do things but apart from that, apart from the fact I go out and do some shopping every day or make myself go out, that's really, that's it, I've got nothing. Nothing to do.

In whatever form, often participants described the necessity of having dependents that provided a reason to get up in the morning. Similarly John talked about the need to come up with some motivation or find a hobby:

So I've got to come up with some sort of, things to do in effect, some sort, put some sort of motivation into my life you know, whether it's doing some sort of charity work or whatever or actually coming up with some sort of hobby that I want to do.

Though he had never "had much of a hobby", finding some activity suddenly had taken on a crucial importance in John's life now that his wife was no longer with him. For both John and Paul it was the physical act of doing some form of hobby or work that they felt they needed in order to face the nothingness of grief. It appeared they were attempting to build their own structure by thinking up things to do or getting out the house every day. These acted as distractions for them both, which they described as "beneficial" to get them away from thinking about themselves or their wives:

(...) a diversion, away from being here, get yourself out, go and join a club, go and do this and go and do that, go and meet people. (Paul)

Life's very hectic at times, to be honest with you. And I suppose in effect that's been beneficial for me because it's, there's always been something to think of apart from me thinking of myself and my wife you know (...) and I think that's the main thing for me is if I can keep busy then I can take my mind off my

problem. (John)

Keeping busy through socialising, as well as household activities and family responsibilities, was of key importance for John and Paul in that it “diverted” them away from “here and myself” (Paul). Paul described how being around people he became ‘outward’ again but, as soon as he came back home, he returned to his “grey dark feelings”. For John it seemed that managing thoughts and feelings was itself a form of labour. John described how he “put off” thoughts and feelings and concentrated on other activities such as driving or being with his grandchildren. At other times he explained, “It’ll hit me and I have to stop what I’m doing and think about it”. Often, other ordinary needs would interfere with these thoughts such as feeling hungry, which would force John to get something to eat which could then “change your course of thought”.

However, within this activity, John told me he was doing little for himself that brought enjoyment. Planning work and things to do was out of the need to have “something in the pipeline”, which enabled him to “get by”. While John was also open to counselling interventions, Paul was clear that he needed to deal with grief in his own way. He felt counselling could not provide anything he did not already know: the answer for Paul was through finding “diversions” from his grief. Laura found, that the activities she used to engage in such as reading she was no longer able to. Like John and Paul, the loss of her husband also meant she lost the source of motivation in her life. Laura described how she would start but not finish anything:

It’s too much effort to finish it, I get bored, and I have no motivation to move forward. Because when I get bored with something my husband would go,

“Oh we've paid so much money for that and you're just going to leave it there, are you really not going to finish it?”. He guilt me and encourage me to move forward, but there's no reason to move forward. There's nothing, there's no reason to my life. I go to work, I come home, I eat, I do the things I'm supposed to do.

Busying the self with things to do was a strategy to fill the space left by the loss of their partners. John reflected spending more time with his grandchildren would probably “take her place”. Resolution was in the acts of doing, maybe taking up golf or getting interested in bowls, John remarked, “I think probably that's how it'll be resolved”. In these examples, it was as if the experience of grief gave rise to a need to be ‘doing’ where distractions gave a temporary anchor in the liminal impasse of a new and meaningless present. As Lewis (1961) described in *A Grief Observed*, grief gives life a ‘permanently provisional feeling’. I noted this provisional feeling in participants’ accounts where grief produced a lack of meaning, incentive and motivation. In the grief over his wife Lewis wrote there seemed little point in starting anything: ‘I yawn, I fidget, I smoke too much’ (1961, p. 30). This was a situation of suspended agency, where the practices that the participants undertook were a means to counteract the sense that everything had become equivalent in its meaning and purpose. This new world brought with it uncertainty and instability which could provide new freedoms or destruction. Much like the philosophy of existentialism (Camus, 1942; Sartre, 1958) this sense of meaninglessness had the potential to be experienced as one of terror and dispiriting futility or of great liberation.

7.3.3 Negotiating space and objects

For the participants, following bereavement was not just a person who was lost but also a motivating force in their life, and the routine and structure that had been created by living with and being in partnership with another person. In participants' accounts, spaces and objects played interesting roles in the management of grief and memories of the deceased person. For instance, places such as cemeteries and gardens were places that participants would visit and use to mark the 'absent presence' of the deceased person (Maddrell, 2013). The influence of the material environment on the participants' ongoing relationship with the deceased person was evident, and impacted in varying degrees.

Another significant space, the home, emerged as an important centre for the participants' grief. The death of a cohabiting partner or family member either fostered a greater (and often ambivalent) attachment to the house and possessions or, in the case of Anne and Tania, a need to move out into a new and different environment. Alternatively bereavement could lead, in extremis, to homelessness as in the cases of Jamie and Saadhia. An increased ambivalent attachment to the home was especially pertinent in John and Paul's account who, after long-term marriages, found that without their wives they lacked the motivation to keep things tidy in the house, having to learn how to cook or being unable to rid themselves of objects in the house. Paul feared that he was becoming a hoarder as he had become "very lazy" as his wife was not around to "chase" him and "harass" him about things that needed to be done around the house. He was also unable to clear his wife's possessions. He remarked that other people had suggested he get rid of his wife's objects but for Paul it would be an act of "betrayal":

And people say “oh why don't you get rid of them why don't you do this and why don't you do that”, I can't (...) She's got loads of clothes, loads of things, but everything is, the way I look at it Caroline, it's like a betrayal. To me, you know.

I interviewed Paul in his home so I had the opportunity to see some of the objects he described. In the living room there were walls of shelves filled with books and DVDs and there were clear traces of his wife, a selection of walking sticks resting in the corner of the room and a selection of women's perfumes on one of the shelves. When Paul explained there was “too much” and “lots of things”, I could see clearly to what he was referring. He explained how his wife was “possessive” over her things and “she knew exactly where almost anything was”:

(...) even a tiny little ceramic thimble she would say it's on the third shelf, little cabinet down there behind the so and so, she knew, oh yeah she knew.

Paul was adamant that he would never clear her things out of the house but I did ask him what he thought might happen if he were to get rid of those objects. Paul paused before telling me he simply could not see himself ever doing it. The attachment was not to his own objects and possessions only his wife's and those things they shared together. John, too, had a similar struggle finding he was still living in the house with things exactly where his wife had left them. John was aware that this was not necessarily what he “should” be doing, detailing his experience in the hospice bereavement group where some of the group members spoke about how they got rid of the deceased person's belongings straight away. John acknowledged that, in

keeping his wife's clothes and leaving the house unchanged, he was "still hanging on to her":

I'm just, I'm not, I don't want to lose her. And I know I have to (...) it's sort of like I don't want to lose her yet. And you think, at other times I think to myself, "Oh, that's being silly" but I just, well it doesn't hurt anybody just leave it as it is, it's only going to affect me so why worry about what other people are going to think.

The only motivator to clear the house of his wife's things was "what other people think" and yet John contemplated that leaving things as they were is not really hurting anyone. In her exploration of how bereaved people used objects in their grieving and memorialising of the deceased person, Gibson (2004, 2008) utilised the psychoanalytic concept of 'cathexis' (Freud, 1917) to portray how bereaved people held on to material objects, not only psychic objects, as a mode of transitioning through their grief. Gibson argued that the objects of the dead carry powerful symbols of their presence. My data support this. Gibson noted the transition through grief often followed a move away from these objects, the objects acted as an intermediary enabling the transfer of the attachment from the deceased person to be integrated back into the ego. However, I argue that for some participants, there was a constant need to maintain their obvious presence in the everyday life of the bereaved person. Objects would 'animate' the presence of the deceased (Hockey et al., 2005) temporarily as part of the mourning process or, in the case with Rose, objects would become more permanently animated by the deceased person, becoming what Gibson (2004) described as 'melancholy objects'. Rose told me:

So I've got this knitted old English sheepdog, massive thing, but if you put him upside down in the bed beside, it looks just like, it looks just like Simon laying there! And he came everywhere with me (...) So it was just like he was there.

Not only did the character of the deceased person animate objects but was also was relocated in space. So while Rose's husband was now brought back to life through her sheepdog toy, her husband's ashes were also somewhere out in the river Thames:

I just poured him out and (...) it goes straight down. No you would not know he was there. And I was just literally pouring him around (...) It was amazing. And because I always say um, I always used to say if Simon was turning in his grave, I think he's out to the Thames by now, well out in the Thames by now. Yeah. If you ever want to picture him, it's an old one, because that's our wedding photo.

Rose then passed me a wedding photo and her husband, represented in the form of a photograph, was in another medium. In Section 7.4 I demonstrate in more detail the fluid presence of Rose's husband and how he emerged in material objects and spaces but also was felt as a bodily presence.

For my participants, I argue, the home acted like a shrine to the memory of their deceased partner where the objects served to keep and sustain memories. But the attachment to the home could be ambivalent – both a comforting and upsetting reminder. The scene of “going home” was described in several of the participants' accounts:

Going home is the worst thing really. Because that's like you open the door

and you, and no matter what happens you expect her to be there, and she's not. But I find that hard even if I'm going down the shops or whatever. It's very hard going home. (Paul)

But yeah since then I moved house, I moved house nine months after he died. Just because purely it was such a huge house to keep on and the fact that we'd found him there, every time I walked through the door it was a reminder. (Tania)

Some of the participants acknowledged that being left with the sole responsibility of the household at times felt overwhelming, leading Paul to become lazy or for Anne to move to a smaller home. John told me he had "a freezer full of food" he did not need. For John while some objects were retained and provided with meaning, other objects, such as too much food, became unwanted clutter. Rose had remained living in the house she shared with her husband, living alone for 26 years. Following the death of her husband, Rose began to hoard objects. I went to visit Rose in her home to conduct the interview. She showed me round her home and her 'clutter' as she described it, which had filled some of the rooms of the house so that it was impossible to enter. As we spoke we sat in the living room surrounded on either side by boxes of Rose's belongings. Rose showed me her bedroom that had just enough space for her to climb into bed with a computer and a TV positioned for easy viewing. From how Rose portrayed it, she had an almost indifferent relation to the objects that congregated around her, as though the stuff had accumulated due to a lack of interest rather than out of a strong attachment. This lack of care was in stark contrast to how she described her husband's control over the home environment; not only in how the house appeared but in the running and organisation of their family, where he was very much head of the family.

My data show that, for the participants, holding on to objects was a way of holding on to the person who had died, yet conversely, the rejection of the home could be a rejection of the influence – positive or negative – the deceased person may have had over the home. This was captured in Rose's ambivalent connection to the objects she hoarded, where she told me that in the event of a fire there was nothing she would attempt to save. Yet her statement was belied by the quantity of belongings that surrounded her. Rose contended her hoard had formed out of indifference rather than attachment, and her indifference was a result of the dominant role her husband had played in their home. However, I argue Rose's accumulation of objects could be read as one of resistance to her husband and the way he controlled the home. In his absence, Rose in her hoarding was reclaiming the space as her own; crowding out her husband's influence, leaving only enough space for her husband that Rose could comfortably manage.

7.4 *Inhabiting and resisting identities*

So far I have presented how grief is something that is performed through ordinary and everyday practices. As Valentine (2013) has suggested, these 'affective practices' enable the repairing of the identities of the bereaved person as well as the preserving of the identities of that of the deceased. Here, I consider how new identities are formed, or old identities are sustained, through these affective practices. I analyse identity as something produced through strategic social action (Unruh, 1983) and also as something that can be narrated differently over time. Overwhelmingly, among my participants, identity was something configured in intimate relation with the

person who had died and the level of presence the now deceased person had in their ongoing life. The narration of identity was thus not solely an individual activity but involved the 'impressions' (Ahmed, 2004) of the person who had died. I also consider those participant accounts that did not claim an identity, and whether failing to narrate an identity can be considered a resistance to or refusal of recovery.

7.4.1 New identities

Participants described how, after bereavement, they felt like a completely different person as well as being treated differently by others. Initially, it was a realisation that one's external identity had changed despite feeling like the same person, as Laura described:

Laura: You know when you read the novels, the old novels where there's a widow in there and she's on the side-lines of everything's that's going on, she's no longer in that part of the family. Because I was always a bit the matriarch in the family, bossy boots, and that role's gone for me now (...) my role has definitely changed within the family, being a widow (...)

Interviewer: Your external identity has changed to other people.

Laura: Yes, yeah. And that's bizarre for me because as you see I still wear my wedding ring, three years on and I will wear it until I die, because I don't see myself as a widow, I still see myself as his wife.

As demonstrated above, for Laura there was a disjuncture between how others saw her and how she viewed herself: "as his wife". In van Gennep's (1960) 'rite of passage', to enter a liminal phase is to lose or forget one's pre-liminal status and

identity. I argue that the disjuncture felt by Laura revealed how her identity was in transition, 'betwixt and between' social positions. To those around her, Laura had lost her previous identity and status, yet Laura was not willing to accept the new status of widow. This liminal identity could be unsettling to others. As discussed in Chapter 3, the bereaved person embodies the divide between living and dead people, polluting the clear boundaries between life and death. For example, Paul remarked how as a sociable extroverted person he was treated as a "pariah" where people would avoid contacting and coming round to see him. The way in which people avoided her after her husband's death made Anne feel as though "[bereavement] might be a contagious disease". Equally, being placed within this new undesirable category was a motivator for Tania, who acknowledged the gulf between the identity she had come to inhabit and who she wanted to be: "I just wanted to be Tania again rather than the woman whose lost her husband". I asked Tania whether there were moments in her grieving where she felt like she was no longer herself, to which she replied:

Yeah and it annoyed me because I remember thinking I am not this weeping wailing depressed woman, I'm not a depressed person by nature. I've always, always been quite optimistic and it used, it just really upset, sitting on my own at night thinking this is not me, this is just not me.

Tania and Anne described how this change in identity also provided the impetus to transform their lives in positive ways. Indeed, both Tania and Anne explained how they were "quite dependent" on their husbands and narrated a sense of disbelief and surprise at the person they had now become. As other people acknowledged her change in identity, Anne also recognised for herself that her identity had changed, when her friends could no longer understand her:

I'm a different me. I can't be that person, because that person is reliant on having another half. And I have to be a different me, I have different priorities, I have different ways of looking at things, and I'm harder. It's just, you can't see life the same way anymore.

As both women had married their partners in their early twenties, they found themselves alone, a new experience in their adult life. This was coupled with being forced to take sole responsibility for their family and children. However, this new circumstance provided Anne and Tania with new confidence who both felt that they were a "better person" now. It was, as Anne described, an "interesting conundrum" for Anne liked the fact she was "stronger" and yet would rather be "back there" when her husband was alive. Rose too explained how she changed after her husband died from "always being the follower on" to taking control over the decisions in her life.

However, while Tania's change in identity was a process of striving to be "me again", for Anne it was a process of learning to be a new person without her husband. She explained a scene from one of the *Harry Potter* films, to describe the feeling, where Harry Potter's godfather died and fell through a curtain but Harry could not go through as it was a one way door. For Anne this was illustrative of how her husband had gone in one direction and Anne had gone in another, which had sent her on a new journey. She described this movement into a new life as jumping from one set of train tracks to another:

I think of train tracks where his track went that way, my track went that way. I fought so hard physically to bring time back and to follow that track, (...) and

it just diverges and diverges (...). So it's just a different journey in my view. (...) And I felt almost like I was the one who died because I have started a new life. It's like being jumped off one set of train tracks and on to another set of train tracks that are heading off in a different direction.

Despite her efforts to follow her husband's train journey they were headed on two different journeys for better or worse. Anne had entered a new "blitzed landscape" that was a far distance from the "simple person" and "normal" life she used to share with her husband. Anne found she no longer recognised herself or the world in which she had arrived. In this way, the journey Anne described captured a 'rite of passage', where Anne moved through liminality to a new identity. However, as I discuss next, arriving at a new identity for the participants was not necessarily a process of detachment from the deceased person but one of maintaining, reconfiguring, and persisting in - often ambivalent - relationships.

7.4.2 Relational identities

Somebody's going to suffer grief in a relationship at the end of the day because you're not going to go together. And when that happens it's the most, well ooh can't describe it. I can't describe it; it just tears you apart inside. (Paul)

For all participants their relationship with the deceased person was both close and long term. Following bereavement, participants narrated the difficulty in facing up to the realities of entering relationality and the risks involved in the possibility of losing the other. It was a risk that, as Paul acknowledged above, was known, but which one

was unable to face up to until it actually happens. For Derrida (2001), all relationships bring with them a sense of mourning in that the formation of a bond rests upon the inevitability of separation. The precarity of ties can feel ameliorated by the consistent presence of the other person but in bereavement, the loneliness, loss and ambivalence comes to the fore. The feeling of loneliness was particularly marked for John and Paul who had spent the majority of their adult lives married and living with one partner and now found themselves alone and, as detailed in the last section, losing motivation and incentive and the ability to manage the household. As Paul described:

The only way I can describe it is literally part, half of my life has disappeared.

The light has gone out of my life and it's a sod to deal with it.

Paul narrated at length the life he had with his wife emphasising how close they were, never spending a night apart for forty years. For Laura, being in a couple had provided the confidence to be herself, a self-confidence which had been lost along with her husband. She found she was reluctant to go out to social activities without her husband who was six feet tall and "built like the side of a barn". The description of his physical presence illustrates how he provided "grounding" for Laura:

So it makes it quite hard to be social, which has got worse since my husband died, much, much worse. Because I have no grounding. He grounded me and would say "Oh don't be silly" and there's no-one to do that now (...) So I think becoming a widow highlights your inadequacies (...) You're not quite so sure of yourself as you are when you're in a couple.

Being in a couple provided a protective cushion almost from the outside world to which Laura felt exposed without her husband. After the death of her mother, Saadhia described how the sense of safety and “belonging” had gone. Saadhia narrated a story of an intimate relationship with her mother:

My best friend, my Mum, everything in one. If I had problems she was there and she knew what to say (...) And I miss all that because she just gave me inspiration, hope, support.

Saadhia struggled after her mother’s death, finding herself unable to maintain a job. When she was evicted from her flat Saadhia described feeling “there was no-one holding my hand”. After finding herself homeless and seeking help from a local shelter, Saadhia looked to her mother for inspiration to enable her to remain “strong”:

Mum she's still there but she would want me to sort things out and get on with it rather than sit in a corner crying for her.

The presence of her mother persisted in the new life Saadhia was forming, which involved finding a place to live and attending counselling sessions. The consequences of no longer being a unit were not always easily resolved. Saadhia and Paul described how they would still hear the voice of their deceased mother and partner. Paul illustrated this to me by mimicking his wife’s voice and the distinctive way she said his name. For Rose, her husband’s presence featured in her life in a more encompassing way. Rose regularly spoke with her husband and felt his presence particularly at certain times and places:

And as I say, I'm not really psychic but sometimes Simon really feels as if he is here, certainly driving he takes over. If I'm driving through (place name anonymised) or somewhere in that area that I don't know, I go oh Simon where am I and I'll just go purely on to autopilot and I'll start driving around and I'll find I'm at the main road, and I'll go thank you Simon! Love you! Bless you! I've told him I love him and bless him much more than, I don't think ever told him when he was alive. Yet we've more conversations, we've better conversations now he's gone than when he was here! (laughs) (...) I just talk to him as if he was here. You lose things, he's amazing. Brilliant at finding things. You lose a CD or a memory stick and you're looking everywhere for it and you can't find it and you go Simon please help us.

It seems, the presence of Rose's husband was useful, preventing her from getting lost and helping to find lost objects. Because of this presence Rose explained that she hadn't really grieved. When I asked her why she thought she had not grieved Rose replied: "It's because he's with me". Rose recalled two incidents where she felt she had grieved over her husband's death, where she shortly received a sense of reassurance from her husband:

I got this this, not exactly a hug, but a feeling of it's alright thank you very much, we've got work to do. So I wiped my eyes and got on.

The partnership Rose had with her husband had continued 26 years on after his death. I asked Rose whether she had a desire for another partner:

No! No as I say, he's company enough quite honestly if I want to talk to

anyone I can sit there and I know his reactions to conversations so much so I know exactly how he would answer things. So sometimes I would come home upset and I would go Simon what do I do now and I feel him just say right okay, we'd sit down let's go through what is the problem and I would hear his thoughts.

Rose remarked that she felt a closer bond with her husband now in his death than when he was alive. She narrated the story of how they met and how they "were always destined to be together" and "absolutely in sync all along". Rose described also how she begun to take on the characteristics of her husband and how other people had commented she sounded, "just like what Simon would have said". The continuing intercorporeality of Rose's relationship with her husband illustrates Ribbens McCarthy and Prokhovnik's (2013) argument that the personhood of the deceased person continues to exist through the body of the remaining partner.

However, the way Rose narrated her relationship was full of complexities. So while she said it felt as if "we're still together" she also described the peace she had not being with anyone and being her "own person". Her husband and the conversations they had certainly seemed to bring her comfort and reassurance and meant she appeared to have not experienced some of the pain of grief expressed by other participants. Her seemingly "melancholic" attachment to her husband was counteracted by how she acknowledged her role had changed since her husband's death. In the absence of her husband she was no longer "just the washer up-er", but the head of the family. She described the funeral as her first social activity without her husband, wearing red and "larking about with his mates from work". Rose's grief was cushioned by the on-going presence of her husband and yet her life was also one

in which she experienced more freedom in his absence.

The ongoing presence, or the ongoing absent-presence of the deceased person, could prove overwhelming, as it was for Saadhia before she began to incorporate her mother's memory to build a new life. For Rose however the presence of her husband was a helpful companion. Yet this post-death identity of her husband appeared in contrast to how Rose had described her relationship with her husband when he was alive. Therefore, it was not only Rose's identity that had changed but also her husband's. For all the participants, as they narrated their experiences to me they would speak at length of the character of their partner or family member, constructing and re-constructing their identity. This was most marked in Rose's account where after death she was provided the opportunity to develop the relationship with her husband to what suited her; changing his identity so that she was no longer the "follower on". In this way there was no ambivalence about her relationship with her husband that made his continuing presence comfortable to live with.

My data show that after death, the relational identity one had inhabited in a partnership may continue, but that partnership also continued to change and develop. I suggest, the way in which the relationship developed was due to the level of control the participants' felt they had over the deceased person's presence. Maintaining control meant the presence of the deceased person could be incorporated into the self rather than becoming overwhelmed by memories or hearing voices. Finding this sense of control meant that the relationship could be shaped to one's choosing. In other words it was a way of overcoming the ambivalence that existed in the relationship when the other person was alive.

7.4.3 Resistant identities

Here I reflect on what I describe as 'resistant' forms of identity. I use resistance to refer to those forms of activity and identity that are described as examples of people failing to recover. These examples of resistance to recovery were described in the accounts of the bereavement counsellors and support workers in Chapter 6. The resistant identity emerged as something in participant accounts as an image of something to avoid. For Tania it was witnessing "career widows" that gave her the incentive to get "fixed" by seeing the life and identity she wanted to avoid:

I do remember going to the WAY Foundation, they had a coffee morning (...) and there were women - I can't, I don't know, they were just not like me. I just remember walking in going I wouldn't be friends with any of you in real life at all. I remember sitting down, they were all chit chattering away, I just sat there and burst into tears, this older lady came along and she said "I'm ten years down the line and it does get better" and I remember looking at her thinking, "Oh my god". And I made my excuses and left and thought I don't want to be like this, I don't want to be sat around in widow's groups like this ten years down the line (...) I wouldn't go back there, I've never been anywhere else to do with WAY. But I remember that terrified me I just drove home in floods of tears going, "Oh my god this is it, I do not want to be like this woman ten years down the line".

It seems, rather than fostering a sense of membership, attending the WAY support group produced a strong sense of not belonging, allowing Tania to demarcate herself from the other women as being "not like me". The "career widows" whom Tania

described loved to sit around chatting to other widows, seeming “quite stuck” and not wanting to “move on”. Tania explained how she and her friends could “spot” the career widows:

We can now spot them a mile off, we're just like oh career widow, which is really awful!

Tania used similar language to bereavement counsellors, describing the career widow as being ‘stuck’ and not wanting to ‘move on’. For Tania too, recovery or its failure was an individual choice. I argue that describing this set of people as “career widows” suggests the work that is also involved in remaining “stuck”. Life’s work becomes about widowhood, which for Tania was something to prevent.

The career widow emerged as a performance arguably framed by the cultural expectations of widowhood and the obligation to recover from grief. Resistant identities, then, were those that performed grief almost too well, but it also included those who failed to perform grief at all. Rose explained how, at the funeral, she was “laughing and joking” rather than crying, where the vicar thought her sister-in-law was the one widowed who, unlike Rose, was dressed in “the full regalia” and wailing. After the service a family member came up to Rose to exclaim, “But you could have least have cried!” and Rose remarked, “blooming heck I’ve supposed to have cried”. Rose’s ‘failure’ to perform the appropriate identity of the widow at the funeral permeated the rest of her narrative. In her one encounter with a counsellor Rose explained that the counsellor had tried to figure out why she “hadn’t grieved”. Rose’s inappropriate display of emotion was construed as a failure to grieve and yet as detailed above, for Rose grieving was unnecessary for her husband was not lost but

still with her. Reading resistance in the participants' accounts thus produced a more ambiguous picture of how resistance to grieving might be interpreted. Using the varying frameworks of recovery maintained by the bereavement counsellors, for example, meant the participants' accounts came into view as recovered and non-recovered depending on which framework was adhered to.

Saadhia narrated her experiences following the death of her mother in which she appeared to enter a downward spiral:

My moods were going down and I was either eating so much to comfort myself or I was just like, "No I'm not doing it". I stopped, I stopped listening to music, the things I enjoyed I stopped doing all those (...) Emotionally inside I wasn't feeling good and I was feeling that I was going to go down and down (...) and I keep hearing my Mum calling me and I think it's real, when I wake up from this sort of sleep I'm like, "Oh my god" and she's not there and I can't look at her picture, I just can't do it. Because I'm just, then I'm just drowning in tears all the time (...) I got to a stage where I was drinking, I was smoking and I just wanted to die basically.

Saadhia's was a story of self-destruction but it was also a story that ended in recovery. At the interview she told me that now she could speak about her mother at length whereas before she would be unable to speak without bursting into tears. I argue my data show that the ability to narrate suffering was a privileged one in that being able to speak to me and respond to questions was only possible from a place of relative recovery. In this process I discovered that though I had set out to uncover the experiences of non-recovery, it was not an experience that could be discoverable via

talk and the interview setting.

Further, the resistant identity comes into view only by its failure to achieve a recovered identity. The career widow was a negative identity in the double sense in that the career widow was formed by the inability to move on and perform grief successfully. Thus, the only way to read resistance was to explore what participants did not say and also acknowledge the limits of my listening. This problem was illustrated when I met Jamie. I got into contact with Jamie through the cold weather shelter at Caris. Caris had carried out their own research into the links between bereavement and homelessness and were very keen for me to engage with the area. Jamie had cancelled scheduled meetings on more than one occasion and it seemed the interview might not happen. He appeared to be a hard person to pin down with a hectic and disorganised life. In our interview he did not wish to be recorded. The notes I made following the interview were scattered and that is how I recall the interview. Jamie was unsure what to say, he told me he'd never spoken to anyone before about his experiences. He described incidents where he felt dismissed by other people and so decided not to speak to people about his feelings of grief. He told me about how his sister died suddenly when he was 16 and then years later his mother died of cancer. He told me how he had periods of depression, alcohol addiction, being made redundant and homeless. It was a story with little resolution where he had lost the two people he loved the most and now experienced a "missing link" in his life.

I found that listening to a story without resolution was difficult and uncomfortable to bear. On reflection, I felt a sense of responsibility to resolve his story, and considering the mobile text messages I received from Jamie following the interview it appeared he was looking to me too to help resolve his story. I realised I also was complicit in the

narrative of recovery and the requirement for a standard story of grief. Yet the resistance to recovery is as much a construction as the notion of recovery itself. I recognised I was reading Jamie's story as a resistance and a failure to recover because I was working within a particular construction of recovery. Resistant identities could be acts of performing grief too well or not enough, and they can also be what a person comes to inhabit when they fail to narrate the 'right' story. But these identities are produced, inhabited and resisted in different ways.

7.5 Conclusion

In this chapter I have presented the ways in which bereaved people navigate their way through a new and liminal landscape and the strategic and social activities that involved narrating a story around the death, making meaning from experiences, engaging in everyday rituals and practices and negotiating space and objects. My data show that through this navigation the participants discovered they came to inhabit and resist new and old identities, often through a process of relating to the presence of their deceased partner or family member. I emphasised the important role of the ordinary and mundane activities that might alternatively be viewed as 'distractions' from grief work but were described by the bereaved person as crucial to their ability to get on with daily life. These forms of work, and not just formal forms of grief work, were used as forms of identity preservation and repair.

In the data from the bereavement 'helpers', the emphasis was very much on the internal work of the individual. However, the data from interviews with bereaved people highlighted the presence of the dead person and how daily life and identity

was structured relationally. At times this presence could be ambivalent, and the home space and objects often became the stage upon which the desire to both 'hold on' and 'let go' was played out. I argue that acknowledging the ambivalent nature of relationships with others dead or alive is a better lens through which to view the experiences of the bereaved person than describing such a state as 'stuckness'. Using such a term as being 'stuck' fails to recognise that there is a great deal of movement and negotiation happening.

Yet the stuckness of wanting to hold on and let go is also a double-bind, where the desire for an ever out-of-grasp past resists the construction of a new identity and future. As discussed in Chapter 6, for bereavement practitioners, being able to construct a new future was an important part of recovery. Yet the transition from a future with another person to making plans on one's own met with mixed success across the participants' accounts. For example, John, in his wife's absence, had no desires or wishes for the future:

[M]y future basically was, was with my wife. That's the only thing I'd ever thought about really that we'd be living together until old age and sitting in front of a fire all that sort of thing, reading the paper or something that things would, that that would be my future. And that's probably part and parcel of the trouble I've got, trying to come to some sort of resolution as to what my future is now, in that I always saw my future as being with her.

In the absence of a future all that remained was a persistence to keep going through the use of different forms of grief work, distractions, and material objects and spaces. Recovery was not necessarily an idea with which participants identified: the vision

they narrated was more one of “muddling through” (Anne), a “road that’s not ever gonna run out” (Paul). Similar sentiments appeared across participants’ accounts, detailing a tiring process of picking oneself up and “plodding”. These stories could be viewed as the unglamorous face of recovery, stories of plodding and exhaustion and getting on with it. ‘Getting on with it’ might seem a limited goal in the face of the transformative power of recovery. Or it is possible that stuckness is the search for bigger and better fantasies than the normative vision of recovery, where the future is still under revision and identity remains in flux.

CHAPTER 8

Discussion of key themes: Meanings, practices and identities

8.1 Introduction to the chapter

In this chapter I draw together the themes that emerged from the data. In this thesis I have argued that people who experience grief find themselves in a state of liminality. I have shown that this state of liminality is in part fostered by a modern fragmentation of grieving practices, leaving no uniform structure to the 'rite of passage'. However, I have argued that the individualisation of rituals and practices, and the dispersion of authority over death, has not meant that the experience of grief is without structure. Rather, through exploring the role of politics, psychiatry and bereavement counselling I have shown that a number of theories, policies and practices exist that aim to support people through the liminal space of grief, which have become new ways of mourning.

I have also demonstrated conflicts and ambiguities in how the boundaries between grief and recovery are negotiated. What it means to fail to recover from grief has been at the heart of my inquiry contending that the exploration of non-recovery can reveal much about how the boundaries of grief and recovery shift, and how they are drawn differently depending on where a bereaved person is located in the liminal space. As discussed in Chapters 5, 6, and 7 behaviours associated with complicated or prolonged grief were viewed from the practitioner perspective as showing how the bereaved person was 'stuck' in their grief, and in turn presented 'resistance' to the normal course of grief. I have used Foucault's understanding of resistance to argue

rather that this form of resistance is a by-product of the discourse around 'normal' grief, which demarcates the boundaries around appropriate emotional expression.

In the following three sections I bring together these issues and debates under the themes of 'meanings', 'practices' and 'identities'. I focus on: how different groups and individuals make sense of grief and recovery; the types of 'affective practices' used, in order to manage grief; and the identities people come to inhabit in the liminal space of grief. I view these themes as interwoven. I argue that dominant discourses around grief affect how people experience and make sense of grief, and the ways in which grief is interpreted has implication for the types of identities people inhabit. Further, this process of meaning-making and identity construction is performed and acted through embodied practices, both publicly and privately.

8.2 *Making sense of grief and recovery*

In this thesis I explored a number of different contemporary western discourses that seek to both define and make sense of grief. These discourses have been largely of a psychological or psychiatric nature, where understandings of grief have enabled a therapeutic response to recovery. I have also considered how grief is framed by political and economic concerns as well as how grief is expressed in literature and autobiographical memoirs. In my focus on the psychological, political, and cultural framing of grief and recovery, I aimed to resist the idea popular in literature on death that, with the decline of religion, people are left with no resources with which to make sense of grief (Walter, 1999). Instead I explored the discourses that continue to shape grief, albeit in different forms. Here, I draw on my data to describe the public

and private ways people make sense of death. I argue that making sense of grief involves medical, rational, ritualistic and instrumental explanations. For example, participants drew upon both rational and traditional discourses, finding symbolic meaning in pain and bereavement through signs, superstitions and metaphors but also relied on more established ideas such as grief models and bereavement counselling to make sense of grief. I also reflect on what happens when there is a failure to make sense of grief, drawing on the understanding within counselling and therapy that being unable to find meaning from grief is also the cause of being unable to recover from grief.

8.2.1 Public and private narratives about grief and recovery

One undisputed claim made by participants was that grief was a natural and normal emotion. This was stated as a self-evident premise, yet on closer inspection this was a multi-layered and contradictory statement. Describing grief as 'natural' acknowledged the understanding that grief was a universal human emotion, the 'cost' of the human inclination to make attachments. Studies of grief that drew on the work on Bowlby, who in turn drew on Darwin's understanding of the emotions, promoted the view of grief as a biological reaction to loss (Parkes, 1972). This affirmed grief as an essentially human emotion, with other researchers claiming sets of facial expressions and psychological symptoms to accompany this human response. In Chapter 3, I explored the literature around emotions discovering that there is little conclusive scientific agreement on what they are. I therefore explored work on 'affect' to provide a new take on conceptualising emotions, shifting focus away from the mind and instead towards the body. I also considered the arguments of authors such as Ribbens McCarthy and Prokhovnik (2013) that emphasised the embodied

experience of grief.

My data show that grief was presented as something indeterminate that could move location, defined according to both the 'outside-in' and 'inside-out' theory of emotions I introduced in Chapter 3 Section 3.2.1. Grief was alternately described as a possession (something internal) or something one could be possessed by (external to the person). Both groups of participants – practitioners and laypeople – described how grief could be triggered or appear without warning, and that grief was capable of being able to 'hit you' unexpectedly. Grief was either inside a person and needed to be externalised as presented in the GRM, or something that became incorporated as a permanent part of the body, as reflected in the 'growing around' theory of grief.

Defining grief as a bodily, human emotion was significant for how grief came to be understood as a problem of the individual and something the individual was responsible for keeping under control. In Chapters 5 and 6, I presented how grief had become framed as a problem in the political and economic spheres. Unlimited grief becomes a 'burden' in a society that favours happy emotions, efficient mental health services and remaining in employment. Howarth (2001) has described how, with the destabilisation of religious narratives and a diminished belief in the afterlife, life and death have become separated so that death is no longer a continuation of life, but a threat to life. Grief too in its expression of loss and death is out of place in a society oriented towards life rather than death. It is thus unsurprising that the concept of recovery with its allusions to rebirth and revival of the individual has been embraced by mental health care, and in models of grief, where recovery serves to rescue the individual from the polluted boundaries of death and depression. In Foucault's (2003) conceptualisation of modern power, detailed in Chapter 3 Section 3.2.2, he

described a shift from a sovereign power, which gained its power from the threat of taking life, to the modern form of 'biopower', which gains power from monitoring, managing and producing life. For Foucault, biopower 'literally ignores death' (2003, p. 248). This ignorance of death, I argue, is evidenced in the politics of the happiness agenda. Within the culture of recovery, where mental disorders are framed as an economic burden, power is directed to managing the deterioration of life, emphasising human productivity and flourishing.

With the decline of religious narratives that traditionally furnished individuals with a world-view within which to make sense of death and feelings of grief, key academics have argued that psychology has grown in the western world as a means of providing counsel for the internal life of human beings (Howarth, 2000, 2007; Rose, 1985, 1989, 1998). In Chapter 2, I documented how grief had become an object of concern for psychology. The psychological study of grief identified the 'normal' course of grief, allowing grief to become measurable and classifiable into normal and pathological forms. The psychologists who conducted the early studies of grief categorised the experience of grief, describing it as a process with phases and stages. This was solidified in Kübler-Ross's (1970) five stages of grief. As I found among participants' accounts, even if the five stages did not fit the reality, they remained a measure against which they defined themselves or, for the practitioners, their client. This use of the five stages, echoed the findings of Wambach's (1985) study discussed in Chapter 2. The similar findings in my data to Wambach's earlier study are evidence of the way in which the stages of grief have persisted in the popular imagination, as well as professional practice.

Furthermore, constructing grief into a process standardised the time limit on

grieving, establishing a time limit on grief signals when grief should end and recovery should begin. My data show that having a sense of the 'normal' course of grief gave those working within bereavement care an idea of when grief stopped being normal and started being 'prolonged'. However, 'normal' tended to be emphasised by the bereaved participants and the bereavement care practitioners not to imply one 'norm' but to embrace a varied number of behaviours under the category of 'normal'. On the one hand, this meant 'normal grief' could encompass a wide range of feelings and behaviours. Especially for the bereaved participants, the meaning of grief was very personal and reflected the idiosyncrasies of their relationship with the deceased person. On the other hand, while it was agreed that grief was individually expressed, from the practitioner perspective, common traits could be identified. The role of 'normalising grief' was for bereavement counsellors and support workers a way of reaffirming grief as a 'natural' human emotion.

As I described in Chapter 5 Section 5.2.1, the growing medicalisation of grief that seeks to provide a scientific rationale for grief has left individual expressions of grief the preserve of literature and autobiographical accounts. Bennett and Bennett's (2000) study of bereaved participants who experience the presence of deceased people was revealing in that the participants interpreted their experience of the presence of a deceased person through both a scientific and supernaturalist interpretive framework, opting for a different discourse depending on the circumstance in which they provided their account. This suggests a disjuncture in the public narration and private experiences of grief. In Chapter 7 Section 7.2.1, I discussed how the bereaved participants used a mixture of both rational and symbolic explanations to describe their experiences of bereavement and feelings of grief. For instance, Rose described the signs that suggested her husband's pending

death, signs not of a medical nature but of a vase of lilac and how it symbolised a death in the family. Anne made reference to the story of Harry Potter by J K Rowling to symbolise the transition of her husband to another world. Further, Anne told me that although her original religious faith had diminished following bereavement, she believed in multiverses, and that her husband's spirit lived on in a different dimension. Therefore both 'professional' and 'lay' participants, drew on a mixture of discourses from formal training and from personal experience of bereavement. For some the grief theories resonated, others found comfort in spiritual ideas. So while the public narrative of grief appears to give a clear outline of stages and tasks, in the daily experience of grief people used a variety of discourses to make sense of grief. This creative exploration of meaning-making reaches its limit however when one fails to make sense of grief.

8.2.2 Failing to make sense of grief

In Chapter 7 Section 7.2.2 I introduced the account of John who struggled to make sense of his wife's death. John felt the need to write down the timeline of his wife's illness and death in the hope that in doing so he would have a clearer understanding of, and perhaps an answer to, what had happened. Similar sentiments appeared in bereaved participants' accounts; disbelief at the death and dissatisfaction with the medical or other authorities to effectively manage, prevent and make sense of the death. In participants' narrations of their stories it was the apparent failure of such external authorities that hindered their ability to make sense of the death. The authorities that people might turn to in order to make sense of death, such as medical professionals, had failed to provide a satisfactory discourse that enabled participants to make sense of death.

Taking into account Frank's (2010) argument that narration is a moral impulse, not having a narrative or story about oneself and one's experience apparently has a high price. In this line of argument the refusal to narrate one's experience of suffering is a refusal of the moral implications of what counts as 'fundamentally' human. In my discussion of the recovery model of mental health care in Chapter 5, I detailed how the experiences of service users are increasingly presented by mental health services as stories of recovery (Carson et al., 2010; Central and North West London NHS Foundation Trust, 2014). However, a growing number of service users have argued that their stories have been sanitised of elements of resistance and incorporated into a neoliberal agenda (Costa et al., 2012; Rose, 2014). For these mental health service users the truly radical move has now become to remain silent about one's 'story' and refuse to narrate one's life and experiences (Costa et al., 2012).

This resistance to storytelling has emerged in the realisation that telling one's story can have limited reach in producing change. I argue too that in my data, for the bereaved participants the ability to narrate their experiences of bereavement was different to finding meaning and resolution, or to producing tangible changes, either internally or externally. Grief posed a problem that could not be resolved, offering only an on-going and never-ending process of adjustment. Grief was an experience and feeling particularly resistant to the format of the narrative, even as the bereaved participants worked within those structures in their attempt to provide an account of their experience in the interviews. Bereaved participants acknowledged the need that they felt to recover, fostered by those around them. This need to make sense of grief in order to recover was presented in John's account, where the obligation to make sense was somehow at odds with his desire to remain mulling over the events of his

wife's death.

The importance of making meaning from grief is compounded by the therapeutic notion that the way to recovery results from finding meaning (Neimeyer, 2005). Trauma has been described as marking the disjunction between the event and a belated incomplete understanding of the event (Caruth, 1995). It is implied that the cause, or perpetuation of, mental trauma is not having a coherent story and so cures of mental distress are often directed at enabling people to find a story (for example in the treatment of PTSD). This is demonstrated in psychodynamic treatment where the construction of case histories is used to provide meaning and comprehension of events and thus recovery (Goody, 2006). I argue that the danger with implying that narration is a mode to healing is that it relies on the normative idea of having a life that is accountable in 'standard story' forms. Grief stories are then categorised into genres where those who fail to recover or otherwise grieve in a way that could be described as complicated become worthy of features in newspapers that highlight how certain stories of grief are problematic (for example see McQuire, 2015; Moore, 2014; Parris, 2009).

My contention is that the need for a meaningful story relies on an understanding of the world and the self that is always coherent and comprehensible. In this view people need to find meaning, or be assisted to find meaning; there is no option to decide that grief and death are without meaning. Instead I suggest not having a story is not necessarily a descent into meaningless chaos. Rather it could be interpreted as a process of discovering new meaning, or in the spirit of existentialist thought, discovering new freedoms.

I have argued that making sense of grief is a public enterprise, and further that grief is framed within a modern post-enlightenment discourse that values scientific understandings of health and the emotions. Not finding meaning in grief thus becomes problematic to the public narrative of grief where there is little space for unhappy emotions or stories without an end point. While making sense of grief is both a formalised activity and increasingly about individual choice and creativity, not all stories are permitted in the public narrative. Overall, the types of meanings that bereaved participants derived from their experiences were limited to publicly accepted psychological paradigms, often using grief models to frame their experiences. I argue that failing to make sense of and find meaning in grief poses the threat of disorder to the established theories around grief. In a modern culture where death cannot be left without a medical cause, the failure to find meaning in grief and resistance to fitting experience into a meaningful narrative produces the same outcome of non-recovery.

8.3 *Affective practices*

Making sense of grief was an activity that involved not only the ability to construct a coherent story but was carried out in embodied physical action. As described in Chapter 3, I adopted the use of Wetherell's (2012) term 'affective practices' to express the ways emotions are embodied, situated and performed. Here I describe some of the affective practices people used to manage grief that I uncovered in my data. Similarly to the meanings participants constructed to make sense of grief, these practices reflected a mixture of the rational and the symbolic. First I address the rational forms of practice found in bereavement counselling and the emphasis on

'grief work'. As presented in Chapter 6, grief is viewed as something that needs working through via the use of counselling frameworks and methods. Second, I consider the symbolic types of practice where grief is expressed and performed in public and private spaces. In Chapter 7, I detailed the types of informal practices in which bereaved people engaged, negotiating space and objects in the home. I explore further these types of informal rituals such as memorialising people in online spaces, and voicing narratives, where grief rather than being 'work' becomes a platform for individual creativity. Finally, I consider the failure to perform grief, or deviant forms of grieving practices that reveal the social norms that constrain the seemingly 'natural' expression of grief.

8.3.1 Grief work

Bereavement practitioners agreed that grief needs work, or working through. This belief in the work involved in overcoming grief stems from the early psychological studies interpreting Freud's (1917) 'detaching' of the ego from the lost object as formal work to be undertaken in the individual psyche. This was further emphasised by Worden's (1991) 'tasks' of grief, where the language used clearly denoted grief as an active rather than passive process that unfolded naturally. The active need to intervene in grief was based on the premise that left unattended, grief could transform into pathological forms, or 'unlimited' mourning as Gorer (1965) termed it, which had negative consequences for the individual and society. Efforts to ward off the possibility of being 'derailed' into 'complicated grief' (Shear, 2012), led to the creation and need for bereavement counselling, and bereavement care professionals whose responsibility was to ensure grief remained on a 'normal' course. However, as argued in Chapter 6, whether formal 'grief work' actually aids the bereaved person

remains debatable, with some studies finding bereavement counselling to be ineffective and potentially harmful (Schut, 2010). However, this is outweighed by discourses that highlight the 'socio-economic costs' of bereavement, positioning bereavement as a public health concern (SECOB project research group, 2013; Stephen et al., 2014). Positioned as a 'risk', the need for expert intervention and the management of grief is legitimated as an economic and social responsibility. Grief, much like birth and death, is no longer an ordinary life event but a risk, an extraordinary event to be governed and one that normalises the role of experts intervening into the ordinary.

Furthermore what 'grief work' actually involves can seem unclear. In Chapter 6, I highlighted six key components that appeared in the interviews with bereavement counsellors and support workers who assisted in the carrying out of grief work. These components: the choice of method, the personal experience of the counsellor, the assessment process, fostering safety, the 'normalising' of grief and 'emotion work' were not criteria normally described in grief and bereavement counselling literature. My data showed that these criteria were not tick box requirements but rather elements that emerged in the more nuanced accounts of the bereavement 'helpers' that generally avoided describing a set formula for recovery. These elements placed emphasis on the qualities of the counsellor and the client as well as considering the importance of the choice of method that framed the counselling interaction. Grief and its recovery were negotiated in the encounter between client and counsellor. While all the elements may be present, the possibility of failing to recover or resistance remained possible. This fluid process described by the practitioners was in contrast to the inflexible Grief Recovery Method (GRM) where the method was the only means to recovery. In the GRM the steps had to be followed in a set order, and as directed,

where room for failure was due only to an error of the individual griever and never a result of the method.

In the approaches used by practitioners, failing to recover was framed in terms of the client being 'unwilling' to do the work, or by avoiding the work either consciously or unconsciously. Of the approaches, the GRM presented the most extreme example where the method was the only true means to recovery. However, as the bereavement 'helpers' were invested in their own method their commitment to the belief in 'grief work' was unsurprising. Describing grief as 'work' is an appropriate metaphor when personal life is increasingly framed by productivity rather than leisure time. Marx (1976 [1867]), in his description of 'The working day', argued how in a system of capitalism the day is ordered so that the body remains consistently productive. A neoliberal capitalist system of politics and economics that exists in the UK, relies upon 'techniques of temporalisation' (Binkley, 2009) to enable high levels of productivity that also impinge on how leisure time is experienced.

I have argued in this thesis that grief is an experience of liminality. Liminality presents the antithesis to work in its lack of rules and temporal structure. This was demonstrated in the accounts of the bereaved participants, particularly those who were out of work or retired, and how they created their own routine and structure in the absence of 'the working day'; an absence amplified by the death of the person with whom the everyday was once shared. Within the framework of productive work, the practitioners viewed these ordinary activities as 'distractions' from grief work or 'short-term' fixes yet were described by the bereaved person as crucial to their ability to get on with daily life.

Even in times of grief, I discovered in my data, the bereaved person is encouraged to be productive and do one's homework; the effects of discipline showing their traces in conceptualising grief as work. I argue grief work is a 'technology of the self', which as Foucault (1988) claimed, people undertake in the hope it will bring them a positive value such as happiness. The technology of grief work both expects and produces active subjects, willing to follow the method and overcome their grief. Further, bereaved people are also managing themselves; doing the work of surveillance on behalf of the 'authorities'. Grief work thus becomes a collaborative project. In turn, the relationship people have with their own grief also changes, from a subjective feeling to something that can be objectively measured and classified and worked upon.

8.3.2 Performing grief

In light of the death of popular music performer David Bowie, people turned to social media to profess their feelings of grief. For some media commentators this was evidence that the Internet had returned grief to a communal affair:

Public mourning—via Twitter, via Facebook, via Tumblr—has become its own kind of ritual. (Garber, 2016)

In Chapter 7, I described the everyday practices in which bereaved participants engaged to manage their grief, creating daily routines in the household and negotiating attachments to objects. While these activities were carried out in the private space of the home, arguably feelings of grief are increasingly expressed in public forms of memorialising (Garber, 2016; Seligson, 2014). In particular the rising

use of online spaces for memorialising those who die is evidenced as a rejection of the 'taboo' around grief. Garber (2016), in current affairs online magazine *The Atlantic*, argued the Internet and social media sites are giving back grief a platform upon which people can voice their 'natural' expressions of grief. In this view, these new rituals are providing an outlet for the chaotic feelings of grief that had been long repressed by the lack of traditional rituals to make sense of and organise death. Additionally, social media is apparently encouraging collective grieving, where people are forming communities of grief through hashtags, such as #RIPBowie. However, the public mourning of celebrities and public figures has occurred with or without social media: the mourning of Princess Diana being the prime example. The public performance of grief for iconic figures who lived their lives so publicly seems fitting, as emotional outpourings by the public punctuated the lives of these public figures.

Communities for bereaved people exist online in less public settings in the numerous online discussion forums designed solely for the discussion of grief. Many of the widowed participants with whom I spoke told me of the comfort they found in interacting with fellow widows on the 'Merry Widows' online discussion board, providing the participants with a sense that someone understood. Online support provided a space for grief when it felt "the rest of the world" had failed to understand. The 'taboo' around grief is re-emphasised as the bereaved community is 'forced' to 'go underground', making grief feel like a 'dirty secret' (Sidhu, 2015). Online forums also tend to be a space absent of experts, and similar to 'offline' peer support groups, arguably people feel more at ease to speak about their experiences with fellow 'peers' (Paulus & Varga, 2015). Yet, in a study of online responses to bereavement forums, Vargas and Paulus (2013) found that online forums still maintained norms regarding how stories were constructed, albeit in a different form to 'offline'. For example, the

study found people would narrate the details of their bereavement in order to make a claim to the legitimacy of their grief and to be accepted as a member, suggesting similar norms around performing grief existed in the online world.

Social media and the Internet have provided spaces for anyone, including those who are grieving, to tell their own individual story. In a similar way to the recovery model, the interest in narratives and voicing suffering or injustice emerged initially as a radical move to address oppression and inequality. However as argued in Chapter 5, stories about grief, mental health recovery and trauma are no longer hidden and silenced but seemingly abundant. The 'unspeakably taboo' (Walter, 1999) aspects of grief are now shared publicly on online platforms such as 'Modern Loss'¹⁹, which encourages people to share their loss story and participate in 'candid conversation about grief.' The act of narrating oneself, online or offline, emerges at times as a contradictory mix of both a postmodern playful fashioning of selves and identity but also a claim to truth and the revelation of fundamental aspects of being human. Grief is increasingly performed via new mediums yet the belief is that grief itself remains unchanged. In my analysis of literature and memoirs on grief in Chapter 5, I argued for the need to acknowledge why people tell stories in certain ways and not others; what gets told and what gets omitted. I argue that the narration of the story of grief is framed by norms around storytelling and narration but further that in the act of giving one's account, one's identity is transformed in the telling. Telling narratives is not a process of revealing identity but one of constructing it. Despite the openness and diversity that some argue now characterises feelings of grief, boundaries of appropriate grieving are still evident, as I discuss next.

¹⁹ Modern Loss website: <http://modernloss.com/> (Accessed 6 June 2016)

8.3.3 Failing to perform grief

In my data I aimed to explore what might constitute a failure to recover. As argued in Chapter 6, resistance in the counselling setting was depicted as an unwillingness to adhere to the method, as well as a failure to manage emotions appropriately, where emotions were either too excessive or lacking. This was crystallised in the Grief Recovery UK workshop during a small group exercise when a few of the group members burst into laughter. The small group was quickly told by the workshop leader to quieten down. Over the weekend, as a group we had been encouraged to show our emotions whatever they might be. “Let that be okay with you” was the repeated mantra referring to the coming to terms with the feelings of grief we experienced. However in this incident it became apparent that what were deemed ‘true’ emotions were limited to sadness and tears, encouraged by the individual tissue boxes placed under each chair. Laughter was interpreted as an avoidance tactic and not a display of emotion. Laughter and other emotions were framed not as merely bodily responses but as a display of moral character. Laughing at the workshop was a moral failure, a sign of avoiding the work and of preventing completion.

The moralistic nature of grieving is showcased in ‘disenfranchised’ forms of grief (Doka, 1989). Disenfranchised grief refers to feelings of grief that are deemed socially inappropriate. Arguably in modern western societies a hierarchy of grief exists (Robson & Walter, 2013), revealing a disjuncture between individual feelings and the social role one is expected to perform. Goffman (1959, 1963) in his concept of ‘front’ and ‘back’ stages described how people put on different performances in different contexts. The ‘front stage’ is where people perform the ideal or socially appropriate image of themselves. This role is shaped by the desired impression on the ‘audience’ –

the significant others that surround them. Maintaining the performance is vital as a 'minor mishap' can lead the image that is fostered being 'discredited'. In Chapter 7, I presented Rose's description of her husband's funeral where she was "larking about" with her husband's friends, only to be told by a member of the family "you could have at least cried!". Rose had failed to play the widow, a failure that was highlighted in the rest of her narrative where she described a handful of incidents where she had cried over her husband's death. The implication was that the emotion of grief must be in proportion to the weight of the role one occupied. It seemed that Rose's lack of grief was disproportionate to her role as widow. Yet her grief was defined only by the display of particular emotions. I argue that Rose's failed performance on the 'front stage' highlighted the discrepancy between the front and back regions in a person's life. The fear of being discredited – of a 'spoiled identity' – reveals the precariousness of positioning identity in the social arena (Goffman, 1963).

However, as different approaches to grief might show, what can constitute a failed performance is context dependent and thus varies considerably. This counters the idea that grief is 'natural' and only shows itself in particular forms, such as tears and not laughter. Two literary figures showcased in twentieth century classical works of fiction illustrate well the disjuncture in role and displays of grief. Meursault, Camus' narrator of *The Stranger* (Camus, 1942) and John, in Huxley's *Brave New World* (Huxley, 1946) both display inappropriate performances of grief following the death of their mother in different ways. Camus' *The Stranger* begins with the death of Meursault's mother. His emotional state following his mother's death later further incriminates him after he murders a man. As Meursault faces trial the prosecution described that he'd 'shown no emotion' on the day of his mother's funeral. His 'calm' appearance and apparent lack of remorse implicated his guilt further. Commenting on

the character Meursault, Camus (1982) described him as someone 'condemned because he does not play the game'. Rather than merely a social failure or outcast as Meursault is treated in the novel, Camus described him as someone unable to lie, who remained steadfastly to his truth and his true feelings even if they were socially provocative and ultimately not only discredit him but condemn him to death. In a similar way John is the outsider in Huxley's *Brave New World*, embodying the old 'savage' ways of the past. John, at the event of his mother's death openly showed signs of distress, and caused a scene:

The Savage stood for a moment in frozen silence, then fell on his knees beside the bed and, covering his face with his hands, sobbed uncontrollably. The nurse stood irresolute, looking now at the kneeling figure by the bed (the scandalous exhibition!). (Huxley, 1946, p. 228)

Both John and Meursault refused to play the game but remained 'true' to their feelings, a truth contrary to the society in which they inhabited. John found himself in a society where ageing and death did not exist. People did not grow up in families and have a 'mother', and human relationships were pragmatic with the 'individual' of little significance. In the two stories, emotions - in their revelation, or failure to be revealed - showed one's true human character, suggesting how closely connected emotional display and human nature are considered. In each case the showing and not showing of emotions made them both appear less than human to others around them. The need to manage grief is revealed in these points of failure that caused disorder in social norms. Both characters became a site of disgust in their social faux pas.

Disgust also carries symbolic meaning as argued by Douglas (1966) who described

how 'dirt' is constructed as a by-product of systematic ordering and classification. Dirt offends order and must be managed: 'uncleanness or dirt is that which must not be included if a pattern is to be maintained' (p. 41). Drawing from the ideas of Douglas, dead bodies provoke disgust by their association with 'dirt' and fears of contamination. For instance, stories of bereaved people who keep the bodies of a deceased person at home feature in the media shrouded in a sense of disgust and repulsion (for example see Collins, 2012; Porter, 2014; *The Local*, 2014). However, in some non-western cultures keeping the dead body of a family member in the home for several months or more is a traditional custom, such as the Torajans in Indonesia who also periodically bring out deceased people from their graves to give them new clothes and gifts (Bennett, 2016). Bereaved people, I suggest, have the potential to provoke similar feelings of disgust and fear depending on their proximity to the deceased person. Staying too attached, but also not attached enough, can produce negative judgements. Meursault and John's actions caused disorder that needed to be excluded by their removal from society in order to maintain the pattern. Yet disorder also provides the material for the pattern by reinforcing social norms.

The person who fails to perform on the 'front stage' is discredited causing feelings of shame and embarrassment (Goffman, 1963). Douglas described how cultures have provisions for dealing with ambiguity and anomalies. Some of the practices I have detailed here, such as the obligation to carry out 'grief work' and the public performance of socially appropriate emotions are arguably practices that seek to control and manage grief in different ways. At the GRM workshop the small group had to stop laughing and 'play the game'. Those who refuse to play the game have a high price to pay taking Meursault and John's fate as symbolic examples. Formulating a coherent narrative around one's grief might provide a sense of personal satisfaction

and comfort as demonstrated in the accounts of the bereaved participants in Chapter 7, but it also provides a social function in interpreting and imposing a system on an otherwise 'untidy' experience (Douglas, 1966). Furthermore, the comfort one might feel at narrating a coherent story about grief can be construed as being due to the safety of adhering to social norms and patterning rather than any innate need to narrate.

8.4 *Constructing identities*

The ways in which people make sense of and perform grief informs the types of identities they come to inhabit. Here I discuss the third theme of 'identity', focusing on how participants constructed identities for themselves and for others. I describe three key identities that emerged in my data, identities that provided different trajectories through the liminal space of grief. These three trajectories I outline - 'recovered', 'relational' and 'unrecovered' - are identities that might only be temporarily inhabited, rather than an end point in the journey. The temporary nature of grieving identities was highlighted in my search for the person experiencing 'complicated grief' which I document further in Section 8.4.3. Different individuals and groups through a variety of practices, as described above, constructed the three trajectories detailed here such as: psychiatric diagnostic categories, psychological research, counselling practice and individual narration. In each case the identity of recovered or unrecovered is negotiated and contested by the different parties. The identity of 'relational' was one expressed largely by bereaved participants and supported by alternative readings of Freud that highlighted the relational nature of identity.

In Chapter 3, I introduced Bloch's (2011) description of 'the blob' as a way of understanding how the categories of 'subject', 'individual', and 'citizen' are social constructions that provide different forms to the 'blob'. Taking Foucault's approach in the analysis of data, I suspended belief in an essential human subject, which enabled me to identify a number of different 'subjects' that appeared in the data. In my analysis of 'bereaved people', bereaved people were 'clients' and 'service users' but also 'experts'. Bereaved people were 'citizens' of a nation obligated to work and be happy and also acted as 'individuals' or as a 'community'. The bereaved person was also represented by cultural 'figures' such as 'widows' that proscribed behaviours and characteristics. Bereaved people could be diagnosed as 'complicated' or considered 'normal'. Further bereaved people were often characterised by their continued relationships with deceased people, suggesting a relational and distributed sense of personhood. Therefore, in emphasising the role of identity, I seek to highlight that bereaved people come to inhabit *multiple* identities as they move across the liminal space, none of which I argue can be conclusively defined as 'natural'.

8.4.1 Recovered identities

My data show recovered identities can be identified and claimed in different ways. On the one hand, recovery is an objective measure in mental health care. Service users are actively claiming, and being encouraged to claim, an identity that is 'recovered'. On the other hand, subjective definitions of recovery offer myriad ways of living recovery, which embrace the non-normative ways people might live. Throughout my data there was a conflict between these two types of recovery, often defined as 'clinical' and 'personal' recovery, which was not easily reconciled. This was

demonstrated in the recovery model itself that, in transforming a subjective feeling into an objective measure, had faced considerable criticism. The debate over the uses of the term recovery in grief and bereavement also brings these issues to the fore, where recovery appears in different guises such as 'integration' and 'adaptation'. Bereavement practitioners showed caution over using the term 'recovery', concerned about the medical connotations of 'recovery', and instead spoke of "change", "movement" and "newness".

I would argue however that there is a sense of recovery implicit in these descriptions in that bereaved people are understood to be coming back to 'normal life'. If considered in terms of a 'rite of passage' (van Gennep, 1960) recovery signals the return from liminality: changed, but stronger and more efficient. Grief casts people out into liminal space erasing past identities, but providing various props to navigate one's way back. Recovery is a transformation for the better but it is also a transformation back into normal life, constituted by the markers I highlighted in Chapters 5 and 6. Tania, for example, described how she just wanted to get "fixed", expressing an urgent need to be "me" again. Being recovered was synonymous with being a good citizen, keeping stable emotions, being in employment, not being dependent on mental health or counselling services, maintaining one's appearance, having hobbies, having a social life, to name but a few. Being recovered also described internal shifts in the psyche: a withdrawal of energy from the deceased person or an integration of the loss into the bereaved person (Freud, 1917).

Being recovered appeared to be a fine balance that required continual work on the behalf of the bereaved person to maintain. The GRM's notion of completion promised recovery yet it became evident that completion was only a temporary measure. Completion did not signal an end, rather it was a fantasy that forced all those who

desired it to constantly carry out the task of 'getting complete' by writing completion letters. At the GRM workshop 'completion' was the secret tool we had all come to discover. Yet if completion was invariably temporary it was difficult to see the difference between completion and being incomplete. The Grief Recovery UK Director Ellen told me that "you can be as complete as possible". Yet the concept was self-defeating in that it demonstrated how relationships and people themselves appeared to be unable to remain as whole, integrated beings, but rather tended to experience losses, and formed relationships that meant disregarding 'completeness'.

The promise of recovery is a powerful one as it implies that no matter what might threaten the stability of the self, one can prevail. The interest in resilience promotes a similar narrative of hope, that people can 'bounce back' from adversity, and furthermore that resilience is a natural human capacity. A recovered identity was a concrete reality witnessed in the performance of being a good citizen or by a CORE-10 form ticked off in a counselling room that demonstrated progress. However, being recovered also remained a fantasy fostered by a 'cruel optimism' (Berlant, 2011) that a resolution could be attained, forcing people into a continual search for completion.

8.4.2 Relational identities

In the data from the bereavement practitioners, bereaved people were given an identity as normal or abnormal, recovered or unrecovered. In contrast, the data from interviews with bereaved people highlighted the presence of the dead person and how identity was structured relationally. In the bereaved participants' narration of grief it was apparent how much of their sense of self was, and continued to be, structured by the presence and absence of the now deceased person. In Chapter 3, I

drew on the work of Butler (2004) and her interpretation of Freud's theory of mourning to understand how grief can be viewed as an instance that reveals the fundamentally relational nature of humans. The ways in which people 'come undone' by loss (Butler, 2004) reveals the means by which a person's sense of identity is dependent on others. This precarious nature of the self reveals an understanding of subjectivity that is not an autonomous bounded subject but formed in relation with others, and subsequently faces the threat of destruction in the loss of those others.

While attachments can be viewed as adaptive from an evolutionary perspective, grief is the 'maladaptive' response to separation of those attachments (Archer, 1999; Bowlby, 1980; Parkes, 1972). Parkes (2006) described bereavement as the 'price of love' that 'starts a search that is doomed to fail'. This contradiction of human relations is often bypassed in models of grief that encourage detachment from the deceased person, an idea attributed to Freud, even if Freud himself seemed uncertain of its validity. For example, I argued in Chapter 2 that the struggle to understand why people make attachments only to mourn them lay at the heart of Freud's theory of mourning and melancholia. Successors of Freud offered psychodynamic explanations of the choices and investment that people make in significant others, but it appeared that this complexity of human relations was also absent in theories that promote 'continuing bonds'. Rather than overcoming the self/other divide, the continuing bonds theory relies on it, where continuing bonds involves an individual making choices about how they want to incorporate the dead person into their life. Similarly within Ribbens McCarthy and Prokhovnik's (2013) argument for an embodied view of continued bonds, an 'enfleshed' or separate presence of the dead is largely unproblematic, yet the presence of what is bodily absent can often be contentious. This material presence persists as 'us' but also may persist with the deceased as a

separate other with intentional agency. The continuing bond is one-sided, making it not the continuation of a relationship but the formation of a new attachment to an idealised version of the deceased person. For Rose, who continued the relationship with her husband by regularly speaking to him, the relationship was much improved by his death. Her husband's new post-death identity produced a more suitable and compliant partner. The fact that Rose had some control over her life allowed for an equality in their relationship that was absent when he was alive.

The ambivalence that emerges in grief, I argue, also reveals how people are in relation with others in ways that they cannot always control. For Freud, as Carel (2007) points out, all relationships are fraught with ambivalence. Identifying with another always places the self at risk of losing control. My data show that ambivalence imbued the continued relationships, as participants wrestled with gains in the midst of a great loss. For example, in Chapter 7, I described how participants interacted with their home space and objects that became the stage upon which the desire to both 'hold on' and 'let go' was played out. Acknowledging the ambivalent nature of relationships revealed more than describing such behaviour as 'stuckness', which I argue glossed over the movement and negotiation involved in managing such ambivalence. However, I also argue that ambivalent feelings of wanting to hold onto and let go of objects or a person also presented a double-bind for the bereaved participants as what they desired was also the obstacle to a new identity.

My data present examples of how bereavement brings the ambivalence of a relationship to the fore. Carel (2007) argues that the melancholic views the true reality of the process of attachment, comprehending the devastation of not only the person but their sense of self invested in the lost object. The melancholic is thus not

delusional but sees the true extent of what has been lost, while the successful mourner carries out the work only to repeat the same process again, risking once more loss and devastation. Klein's (1940) theory, outlined in Chapter 2 Section 2.2.1 proposed an alternative by showing how by restoring one's lost 'good objects' one can resolve ambivalence by incorporating the positive and reducing bad feelings.

The presence of ambivalence revealed the key issues of power and control in bereaved participants' ongoing relationships with the deceased. Foucault (1984) defined power as being formed relationally, even romantic relationships, he claimed, were not free of a need to enact power over each other. In other words, people are always non-sovereign in relation to one another, non-sovereignty describing a condition of never being fully in control of oneself or of others (Berlant & Edelman, 2014). Identities formed in relation are always reliant on the other, the construction of identity dependent on how one is addressed and how one inhabits and responds to that address (Butler, 1997). Grief and the experience of loss, perhaps like few other experiences, reveals the hold people have over each other. When viewed from a relational perspective, grief is, as Berlant (2008) has described, an experience of 'irreducible boundedness': a sharp separation from the other whom one had imagined to be a part of one's self. This gap between self and other can be experienced as loneliness, as it commonly was among the participants. Thus, the act of attaching to a new person must always remain optimistic to overcome the inevitable risk of loss that is posed when entering into relationality. However, the optimism required for the construction of this relational identity could also become 'cruel' (Berlant, 2011) and an act of resistance, as I describe next.

8.4.3 Unrecovered identities

Here I explore further how 'non-recovery' or 'resistance' can be read, as well as describing my methodological difficulties in finding the person that might inhabit the identity of 'unrecovered'. In the course of data collection, I gathered insight into who the complicated, 'unrecovered' person might be. Across the accounts of bereavement counsellors and support workers differences emerged in how they identified the complicated griever. The responses comprised a number of identities: the ones who failed to perform grief appropriately, as discussed above in Section 8.3.3; the 'career widow' who became consumed with grief; and the person resistant to counselling methods who found themselves 'stuck' in grief.

Overall, however, practitioners agreed that clients had to be willing and able to 'do the work'. The failure to do that work was what would contribute to a failure to recover. In this way, recovery and non-recovery were in the individual's hands, yet counsellors had the capacity to see resistance in their clients, a resistance that would be belied by how the clients might present themselves. For Freud (1914), the role of the 'physician' was not merely to reveal the 'patient's' resistance to them, as if the patient's suffering results from a kind of 'ignorance':

(...) and that if only this ignorance could be overcome by effective communication (...) a recovery must follow. (...) But the illness is not located in this ignorance itself, but in the foundation of ignorance, the *inner resistances* that are the cause of ignorance and continue to sustain it. (Freud, 1914, p. 7, Italics in original)

Revelation will not resolve resistance for one may not know what made one ignorant in the first place, hence why it is sustained. Freud argued recovery was attained only through the patient's own discovery; the physician cannot just 'show' resistance to patient, which may only intensify the resistance. This was reflected in my data where counsellors and support workers would opine that what the client first presented was often not the 'real' issue. Some counsellors spoke further of how clients remained unconscious of what was keeping them stuck, where the counselling setting was an opportunity to bring those unconscious feelings to light.

The role of the analyst for Freud was to judge what had been 'negated' and 'repressed' which he considered the thing that was producing resistance. The aim of the analyst is to remove this resistance and encourage confession and awareness. However, Freud was clear that accepting the solution of the analyst had to be carried out on the patient's own terms. Furthermore, removing the 'inner resistances' was not a straightforward activity. What was producing a client's resistance may not be a singular thing; this foundation of ignorance may be fostered by multiple factors. By contrast, in the GRM, resistance was understood only as resistance to the method. When a method is seen as being impossible to fail, only people can fail the method. Resistance in the GRM was identified in those who analysed too much and were unable to move from the head to the heart, or anyone who queried the method. At the workshop, some group members questioned the relevance of certain activities, but we were encouraged to "stop analysing" and to do the activities unquestioningly, and as such were provided with little evidence of their purpose.

Resistance was not then necessarily active, more a by-product of a discourse that left little room for critique. Incorporating Foucault's ideas on resistance, resistance was

the corresponding discourse to power. People get read as resistant when they fail to be managed, when they fail to embody the subject that lies at the heart of the dominant theory, for example being 'self-integrated' or 'complete'. Resisting the method meant resisting completion, recovery and inner happiness. The shadow of 'non-recovery' at times perpetuated the search for recovery, as presented by the "career widow" who spurred Tania on to "not be like that". The unrecovered identity was a negative identity made apparent only by distinguishing behaviours by their distance from the norm.

Kauffman (2008) described how without the possibility of recovery from bereavement, identity is in a volatile state of diffusion. With no hope of transformation there cannot be any reflexive sense of self. In this way the belief in recovery is needed in order to construct a sense of identity, to orient oneself in liminality. The 'stuck' griever pollutes these boundaries by being neither in one category or the other. The creation of diagnostic categories of 'complicated grief' and 'prolonged grief disorder' have provided a set of individual symptoms, demarcating the person who has 'derailed' from the course of normal grief. The category of complicated grief thus provides them with an identity and enables them to be located somewhere.

Looking for people who failed to recover was a key aim of this research but it became a paradoxical task. During the field work, the subject of 'complicated grief' and the people who might inhabit such a category felt like chasing 'moving targets' (Hacking, 2007). When I attended the Cruse Early Intervention Project, which was designed to target those at risk of developing 'prolonged grief disorder', I was told that 'everyone' in bereavement care knew that complicated grief existed and that only now was it

receiving the recognition it deserved. However, I found that this embrace of the diagnosis was not reflected by the personal experience of complicated grief. The need to identify complicated grief was not it seemed a grassroots movement for recognition, indeed whoever was being diagnosed with complicated grief or prolonged grief disorder seemed particularly hard to find. In my interviews with practitioners I asked how someone with complicated grief might be identified. In the responses I received it was hard to pin down any specific characteristics, or the characteristics were too wide-ranging: from not taking regular baths to unresolved childhood attachment issues. The complicated griever could be just about anyone it seemed.

I soon realised that I was searching for a subject that did not exist, and that in my searching I too was becoming complicit with the construction of 'complicated grief'. When I did make contact with a participant who was likely be considered 'complicated' and of having 'prolonged grief disorder' (Jamie – whom I discussed in Chapter 7, Section 7.4.3), I struggled with situating this participant and their story in the 'non-recovered' space of grief. I could only find the complicated grieving participant if I described them as such rather than the person identifying with the description. In other words, I was 'making up' (Hacking, 1986) the complicated griever. I was using the classification to find the person who inhabited the classification but could not find the person who fitted within it.

Complicated grief, like other forms and varieties of grief – anticipatory grief, disenfranchised grief, protracted grief – was a category that relied upon a notion of 'normal' grief. Yet when that normal was destabilised and revealed to be non-existent, to declare complicated grief existed became untenable. In the same way, I have

argued 'normal grief' was a construction of bereavement research and practice, so too 'complicated grief' was a social construction, one historically specific to contemporary society. If the categories of complicated grief and prolonged grief disorder were not serving a population in need, their purpose was to medicalise some forms of grief while normalising others. The act of diagnosing complicated grief served to distinguish between two sets of symptoms, ones that were 'complicated' and ones that were 'normal'.

Furthermore, the category of complicated grief and the choice to diagnose it relied on a belief that people who are stuck will remain stuck, at least without external intervention. The choice of term - 'stuck' - was particularly telling when considered within the linear process of grief. Getting stuck was getting in the way, taking too long and preventing the normal course. Yet, diagnosing people with complicated grief, in effect labelling people as stuck (my data showed 'stuck' was commonly used by practitioners to refer to 'complicated grief'), was a means to lift people *out* of stuckness, something it was assumed bereaved people could not do for themselves. The diagnosis of complicated grief delineated a clear problem to be solved, which conceivably, allowed grief to become manageable in the psychotherapeutic setting. After all, as acknowledged in my data, bereavement when compared with mental illness has no resolution, for the deceased person cannot be returned and the bereaved person also does not return back to the life and self they knew before. The purpose of the diagnosis of complicated grief was thus twofold: to reiterate grief as a normal emotion (with a linear course), and to diagnose, in order to treat those that were stuck back to normal in line with the process practitioners described as 'normalisation'.

As the bereavement practitioners explained, 'normalising' grief was the key purpose of the counselling process. Making grief normal produced safety and provided the client the coherence to articulate feelings. Bereavement may cause one to confront one's own ambivalence and incoherence, producing the 'discrepancy' (Goffman, 1963) in performance described above in Section 8.3.3. Bereaved people may fail to recover by external estimations but they may also fail in their own ethical standing, causing them to act in 'bad faith' (Sartre, 1958). Performing grief according to the dominant discourses can thus provide comfort or at least the ability to remain out of view of the authorities that seek to manage 'abnormal' grief. The failed performances of grief described in my data then were less reflective of inner characteristics of the individual psyche but rather a product of the bounded categories that demarcated behaviours in normal or pathological forms. Depending on one's perspective, bereaved people became normal or abnormal as they moved and negotiated the lines of power and discourse across the liminal space of grief. Complicated grief was not a thing to be found nor, as practitioners and researchers have claimed, a pathology that has always existed waiting to be defined. Rather the boundary between normality and abnormality – or recovery and non-recovery - was porous and thin. Normality, it emerged, was a performance that was always 'incomplete'.

8.5 Conclusion

In this chapter, I have summarised the three central themes of meaning, practices and identities that emerged from the data. Making sense of grief and how grief is managed has particular salience in a contemporary culture with conflicting understandings about, and explanations of, the meaning, role and value of grief. In the opening of this

chapter I stated my concern with the contradiction between the increasing public face of grief and the persistent belief in grief as a social taboo. The practices people undertake reflect this conflict where grief is both a site for work and discipline, yet also one of creativity and free expression. Nevertheless the bereaved person continues to pose a dangerous threat to stable boundaries by embodying the uncertain and dangerous boundary between life and death.

Focusing on the relational nature of grief, what has emerged is an embodied subject whose boundaries are fluid and porous and formed in relation to others, whether those others are alive or dead; problematising the notion of the autonomous, bounded body. The bereaved person is shaped and undone by relations with other bodies and spaces: intimate, political and social. This body becomes open to intervention when it falls on the wrong side of the boundary and becomes a negotiated and contested site, ever vulnerable and precarious to the power of others. This shapeless evolving 'blob', making its way through the liminal space of grief, comes into view as a category or kind, an entity with form, on the boundaries and intersections of the lines of power, discourse and truth that lay claim to the body, mind or brain of the bereaved person. In these intersections a constant negotiation is occurring; how well a person might endure in these categories depends on a capacity for performance, how well they can play the game, what space there is for resistance, and what opportunities the shifting composition of lines (institutions, individuals, groups, discourse) allows.

CHAPTER 9

The other side of recovery

In this thesis I explored how recovery from grief is defined in theory, policy and practice. I also have discussed how participants who experienced bereavement negotiated the process of recovery. I used the concept of spatial liminality to explore the experience of grief: tracking bereaved people as they navigated their way through this virtual space. Within the liminal space of grief I focused on the boundaries between recovery and non-recovery and how different individuals, organisations and institutions established, maintained and negotiated these boundaries. To build my argument I drew on literature from multiple disciplines, namely: sociology, anthropology, cultural theory and philosophy. I also argued for the benefits of interdisciplinary engagements in the study of grief, in particular the insights from the established field of the study of the emotions. However my methodological approach has remained rooted in a sociological perspective, indebted to the work of Foucault, as I sought to 'problematise' and question taken-for-granted assumptions about grief. Ultimately my aim was to explore the possibility of 'non-recovery' and what happens when people fail to recover (accordingly this chapter is entitled the 'other side of recovery'). From this enquiry emerged three themes: *meaning* – how people, whether expert or lay, made sense of grief; *practices* – how grief and recovery are managed and performed; and *identity* – what type of identities people came to inhabit such as 'recovered' or 'complicated griever'.

Here I draw together key conclusions of the thesis, attending to the aims set out in Chapter 1. First, I summarise my argument for an alternative way of theorising grief; second, I attend to the concept of 'non-recovery' and explain why the failure to

recover matters, and third I conclude my search for the 'complicated griever' by questioning the reality in the construction. In the closing sections I describe the theoretical and practical implications of this thesis and consider possibilities for further study.

9.1 *Theorising grief: Suggesting an alternative view*

9.1.1 Problematising grief as a psychological object of study

In this thesis I have highlighted the shortcomings in how grief is currently theorised through a critique of the overly psychologised view of grief, and have proposed an alternative way of theorising grief. I emphasised the need to look beyond the individual psyche to how grief is experienced, expressed and lived out in everyday life, acknowledging how grief is framed and influenced by political and economic concerns. As discussed in Chapter 2, the 'scientific' study of grief is a modern development, and over the course of the twentieth century grief steadily became an object of psychological study. This shift is clearly demonstrated in the history of Cruse, and presented in the work of Árnason (1998), where the support offered by Cruse, once dedicated to supporting widows with diverse matters such as pensions, financial budgeting and finding employment, is now almost solely concerned with the facilitation of bereavement counselling for adults and children. With the rise of research into grief, institutions and organisations such as Cruse, along with academic journals and bereavement counsellor training, were formed that disseminated and implemented the findings of this research into practice.

In effect what was being created was a new discipline and profession, shaping

bereavement care into what exists today. As part of this shift, grief became something that could be identified in people and measured, with its course defined as 'normal' or 'abnormal'. In other words, grief became something that could be *known*, upon which the growing field of professionals could make claims to the truth of grief. I have argued otherwise that the 'natural course' of grief is a socially constructed notion, which is revealed in the discrepancy between changing social norms around grieving behaviours and how people perform their grief. Later, a new wave of bereavement research critiqued the staged course of grief by taking into account the social and cultural elements of the experience of grief. However I argued that these theories – such as 'continuing bonds' – retained the understanding of grief as a universal phenomenon. Despite the changes in how grief has been explained over time, sustaining a universal definition of grief assumes to know how all people feel. In this thesis I have argued that the divide between 'natural' and 'social' aspects of grief is an impossible one. I have argued that this is made apparent once grief is situated within the broader interdisciplinary study of the emotions, where the extent to which the emotions are shaped by biology or socially formed remains elusive.

As demonstrated in this thesis, the public space of grief continues to be redefined by the interests and policies of different groups, whether from psychiatry, the government or indeed the bereaved person his or herself. Over the course of the century it was not only grief that began to experience 'professionalisation'. In Chapter 5 I described historical developments that shifted perceptions of mental distress and emotions, for instance the prevalence of shell shock in the First World War and the culture of trauma and recovery that followed. Within these shifts, the population's emotions and mental state came to be understood as something only experts could interpret and manage. Moreover, the rise of psychological self-help and counselling

coincided with a professionalisation of the management of death and disposal of the dead body. Arguably the change of responsibility in the management of death and dying resulted in people becoming deskilled in the management of their own grief. Yet at the same time, somewhat contradictory to this shift, the management of grief was increasingly framed as an individual responsibility. Rather than viewed as a consequence of this structural shift in the management of death and emotions from layperson to expert, my data show that struggling to make sense of grief was viewed as a failure, or resistance, on behalf of the individual who was 'unwilling' to make the right 'choice' to recover.

This structural shift thus became diagnosed in terms of individual will, where the individual became the cause of the problem deemed his or her own. As such, victims who resisted recovery were blamed for their failure to do so. People entered into a new relationship with their emotions and accepted the role of the expert to guide and resolve their inner turmoil, and so the 'need' for bereavement counselling became self-fulfilling. Furthermore, as detailed in Chapter 5, within a political and social climate that emphasised happy emotions, with mental health defined as a 'burden', the mental distress produced by grief became a problem from which people were compelled to recover. Recovery became an economic, political and social issue, and the rationale for expert intervention into the prevention and resolution of individual failures was validated.

9.1.2 Highlighting relationality and ambivalence

While the psychological perspective may certainly offer valid insight into the individual experience of grief, the dominance of the psychological perspective has, I

have sought to demonstrate, transformed grief into a diagnosable entity, made measurable and classifiable by psychological tools and tests. As a result, knowledge about grief that lies outside the remit of psychological testing has remained out of view. I argue one of the key elements of grief omitted in the psychological approach is the ability to capture the ambivalence of grief. Specifically, ambivalence creates a situation of suspended agency, which is why the concept of liminality captures well the ambiguous sense of self the participants described to me. I argue that incorporating ambivalence can assist in overcoming the paradox within grief theories that promote a linear process to recovery. But more than this, the experience of grief as one of suspended agency destabilises the vision of the neo-liberal subject: the autonomous individual with the capacity to make rational choices. I have argued that the emphasis on a linear course of grief, affirms the notion of personhood at the heart of models of recovery, such as those popularised within mental health care services.

Instead I have attempted to revive the Freudian claims that underpin much of the research that has promoted recovery from grief as a process of detachment from the deceased person. I have argued that Freud's description of mourning and melancholia displays how grief reveals the relational nature of the self. Indeed, grief poses a paradox to the psychological understanding of grief as a process because the concept of personhood that underpins psychological study fails to allow for a subject who can remain attached to persons after their death. Relying on an autonomous, resilient subject has meant the grieving subject is an uneasy fit for psychological models of personhood, by presenting a subject that both requires attachment to others in order to flourish but is devastated by their loss. I argue this is an elaboration of the ways in which people attach to one another in living relationships. Drawing from psychoanalytic theory, the desire for another person is the desire for the idea or

object that they present. After bereavement, the remaining person remains attached to the same idea or object. The ambivalence that can be felt in grief is a sign of the desire for the lost object. The continued bond is thus evidence of how the bereaved person learned to re-accommodate this lost object as an 'absent presence'. Freud's argument for detaching from the lost object was then, in a sense, the only way to truly recover oneself, if recovery means a return of the self before the attachment. However, this emphasis on detachment overlooks the ways in which people are reconfigured by their attachments and their relationships with others. It might be said then that there is no overcoming the ambivalence of grief, as there is no undoing the ways in which one has been reshaped by the person now absent.

My aim in this thesis has been to make central the ambivalent relational subject, at times incoherent in his or her attachment to others. The presence of ambivalence marks this struggle of not knowing how to let go of the deceased person – or of holding on in the wrong way – a struggle recounted in the psychoanalytic writings of Freud and Klein. Consequently, I have also pointed out the shortcomings of the 'continuing bonds' theory of grief that attempted to highlight the ways in which relationships persist after death. I argue the continuing bonds theory promotes a one-sided relationship, which is not so much the continuation of a relationship, but the persistence of an idealised vision of the deceased person. The continuing presence of the deceased person's identity is a construction that the bereaved person creates and adapts to their everyday life, reinforcing the individualistic notion of the subject the theory set out to criticise. In Chapter 7, I described how the continuing relationships bereaved participants had with their deceased partners and relatives continued to develop and change. Further, being able to adapt the deceased person's identity meant the living person could regain control over the relationship that was not

possible when the person was alive. I argue this was a way of overcoming the ambivalence that existed within the relationship before death.

In this thesis I aimed to demonstrate the importance of analysing grief as a socially constructed experience that is influenced as much by government policy as it is childhood attachment issues. To counteract the emphasis on psychological understandings of grief I expanded my analysis beyond the psychological canon of grief literature to examine developments in mental health policy and political and economic reforms, concurrently with developments in bereavement care practice and research. Only by expanding the types of perspective that come to bear on grief and its recovery can grief detach itself from the association with 'naturalness', which ironically might allow for the 'reality' of grief to come into view. I argue that incorporating a variety of perspectives has enabled a better understanding of the paradox of grief, so that the bereaved person is viewed in such a way that acknowledges the relational and social nature of subjectivity. It also demonstrates how grief – and death – is a continuing concern across the disciplines, and not only within psychology.

9.2 *Why 'non-recovery' matters*

In Chapter 1, I described my interest in exploring the experiences of people who fail to recover. My aim was to analyse non-recovery as a possibility, to bring the concept of not recovering to the fore. In this endeavour I was supported by the archaeological and genealogical methodology of Foucault who sought to bring hidden histories into view. My aim was not to make a judgment on what non-recovery might involve and

how the experience might feel, merely to bring the possibility under analysis. Furthermore, in arguing for the possibility of non-recovery my intention was not to advocate suffering. The question remains - why highlight the option of failing to recover: why does not recovering matter?

In one respect, the argument was simply theoretical: I wanted to draw the edges around the contested meaning of recovery from grief by posing the question of what it means to not recover. Yet it was also an ethical stance and a belief that other experiences were being concealed by the overemphasis, and dominance of, the discourse of recovery. I have argued that recovery discourses privileges happy emotions and happy citizens, disregarding and labelling problematic the experience of the person I have endeavoured to revive in this thesis: the embodied, relationally formed person who experiences bereavement, suffering, and periods of unhappiness, and who may not perform autonomously but is often ambivalently tied to people dead and alive. When recovery promotes a vision of the subject that ignores how people exist in relation with one another, not recovering matters because it reveals the ways in which people are always already vulnerable and non-sovereign when faced with the other; how in a sense people are already incomplete and failing to recover when recovery means detachment, self-integration and autonomy.

I have argued that to recover has become an obligation in a society where grief is understood within time limits and where 'prolonged' grief is defined as an economic 'burden' and a political issue. The complicated, prolonged griever is a problem for the normal routines of modern western living that prioritises neo-liberal values such as efficiency, productivity and autonomy. In this framework, non-recovery emerges as a negative, where not recovering is only ever a rejection of recovery, and consequently

what recovery represents. The shape of non-recovery is formed out of the shadow of what recovery is not, representing the point of failure or resistance.

As explained in Chapter 1, Kauffman's (2008) description of 'no recovery' stimulated my interest in analysing the concept of non-recovery. In his essay, Kauffman explored what it might mean if there was no recovery from grief, proposing a world in which no one recovers. No recovery was not a transitional state but a condition of human existence. I have also argued that non-recovery is not only a suspension in liminality but can become a way of living. While the Grief Recovery Method encouraged bereaved people toward the never-ending pursuit of completion, my interest in non-recovery has been to explore what happens when people remain 'incomplete' or get 'stuck' in grief. Getting stuck presents a problem to linear models of grief, and to the linear course of recovery. The practitioners described the "movement" clients would experience as they worked through their grief, and the problematic 'stuckness' clients experienced when they were "unwilling" to "move forward". Stuckness was thus framed as an unproductive place of "nothingness", yet I have suggested that stuckness be viewed not simply as a place out of which to move.

Grief could force someone to exit his or her sense of 'normality' or assumed world, but in turn I suggest the liminal space might become the new 'normal' space. For example, in van Gennep (1960) and Turner's (1969) description of liminality, liminality is only a phase in the rite of passage that is followed by reintegration in society. As I presented in Chapter 7, participants experienced everyday life cyclically rather than linearly, where plans and routines were carefully crafted on a day-by-day basis, yet the future was hard to manage and envision. The period of 'non-recovery' may have been only an impasse, but for many of the bereaved participants grief

brought with it a new sense of time and space in which they had learn how to live with ambiguity and uncertainty.

Non-recovery might signal the lack of ritual to guide people back towards recovery. But as I have sought to demonstrate throughout this thesis it might also signal the reality that what comes to be considered as 'non-recovery' is in constant negotiation and liable to shift. Recovery and non-recovery are both temporary trajectories across the liminal space that can be renegotiated. Non-recovery is not just a negative space of nothingness, nor is it static, but also a place of dynamic movement. As I described in Chapters 6 and 7, the 'recovered' and 'unrecovered' identities were equally transformations in identities, albeit headed in divergent directions. Recovery is a performance, or as Kauffman described a 'symbolic' gesture, that is achieved by successfully fulfilling the markers of normality. Yet these markers of normality continue to shift and change. Failing to play the game and performing grief the wrong way could incur a moral judgement from others, and the bereaved person could find himself or herself discredited, on the other side of the boundary.

Non-recovery in contrast denotes the failure to measure up to the 'good life', highlighting how recovery has become an obligation of the individual to live a certain way, producing a narrowing of perspective in the different ways people might live out their lives. Yet, as my data show, the pursuit of normality or the good life requires constant work. In the search for recovery and 'completion' bereaved people were driven to write and rewrite 'completion letters', carry out 'grief work' and complete the 'tasks' and 'stages', all in the name of their own freedom. Aware of the threat of becoming 'discredited' in their performance of grief, bereaved people maintain a nervous relation to normal, compelled only by the 'cruel' promise of recovery.

9.3 *The ‘complicated griever’: Construct or reality?*

In my introductory aims I stated my intention to explore the debates around ‘complicated’ and ‘normal’ grief that were taking place in grief and bereavement research and practice. The increasing psychiatric concern for ‘complicated’ and ‘prolonged’ types of grief I argue marked a key shift in bereavement care and practice. What I found, as described in Chapter 6, was that in bereavement practice ‘complicated’ grief remained a contested and negotiated term. Rather than a self-evident diagnosis, practitioner definitions of ‘complicated grief’ were at times conflicting, ambiguous and vague. The fact that understandings of grief and recovery were undergoing this constant process of negotiation, whether in the counselling room or the home of the bereaved person, revealed how grief and recovery were open to interpretation. My data show that for some participants what constituted grief and recovery was very clear to them, but for others less so. How different people within the liminal space of grief drew the boundaries between normal and abnormal grieving, successful and unsuccessful recovery thus became a central focus of the thesis.

However, this ambiguity became problematic methodologically as I sought to capture the account and experience of the ‘complicated griever’. At the outset of the study I chose not to focus on one specific type of bereavement. As a result the liminal space of grief was wide open with which to pose the question: what type of grief gets complicated? As mentioned, speaking to practitioners surfaced conflicting definitions, or definitions that were subtle and vague. From my data gathered from the accounts of bereaved people, grief was something experienced and managed in an individual

manner, where identities of 'recovered' were actively pursued, or else a settling into a new identity that rested neither in 'recovered' or 'unrecovered'.

As discussed in Chapter 8, I could only find the 'complicated griever' if I became complicit with the diagnostic categories of 'complicated' and 'prolonged' grief. Yet I struggled to adhere to the category of complicated grief if it was not an identity with which the bereaved person themselves identified. Furthermore, the methods I chose to employ - qualitative interviews - required participants who could articulate their experiences of bereavement and feelings of grief. The ability to construct a narrative around one's feelings of grief enabled a level of coherence in the participants' accounts, even if that narrative continued to change. I recognised following my interview with Jamie, who refused to be recorded and who struggled with knowing what to say in the interview setting, that the complicated griever rested in these silences, and the inability to articulate their experience.

What initially felt like a failure to fulfil my research aims soon became a piece of data in its own right in that I realised that the dividing lines between normal and abnormal while seemingly definite and clear in theory were conflicted and ambiguous in practice. But further, my own choice of method was inadequate in capturing the experience of complicated grief that out of necessity was constructed on the silence of the complicated griever. The psychiatric diagnosis of 'prolonged grief disorder' drafted in the ICD-11, and the proposal of 'persistent complex bereavement disorder' in the DSM-5, are identified by external symptoms and self-report measures that ask respondents to identify with pre-determined statements. Perhaps by employing these tools I could have identified among the participants those at 'risk' of developing, or experiencing, complicated grief. As discussed in Chapter 8, Section 8.4.3, the diagnosis

of complicated grief makes the problem of grief manageable and provides a clinical solution. But without these tools – and the willingness to use them – I alternatively sought to question the role of the boundary between ‘normal’ and ‘complicated’ grief and how the boundary frames grief into two contrasting experiences. Both what happens in policy and practice and how people make sense of grief in their own words construct the boundary between normal and complicated grief either by reaffirming or rejecting it.

I argue that whatever the ‘reality’ of the experience of the complicated griever it remains in the silences behind the discourse around grief. However, in encouraging the silenced into view the researcher faces the problem, as I did, of reviving and thus constructing a silent consciousness that did not already exist. The articulation of previously hidden silence is, I suggest, changed in the act of narration, and further transformed in the researcher’s interpretation and representation of those stories. In other words, the research process can make the abstract become concrete, but in what form stories are produced requires vigilance in order to avoid the reinforcing of oppressive discourses. Ultimately as researcher in this enquiry I played an equal role in the construction of the complicated griever, by being forced to assume that complicated grief was a quantifiable and thus researchable phenomenon. What remains to be understood is what happens when people come to identify with the category of complicated griever and speak from a place of complicated grief. How people might inhabit the diagnosis will impact on how complicated grief continues to be defined and measured. Furthermore, once a person speaks as a ‘complicated griever’ their identity will be reconstructed in the telling of their account. This might cause the person to move across the boundary from ‘normal’ to ‘complicated’, and back to ‘normal’. But, I suggest, on what side of the boundary the person is located

will not only be a judgment of the person who speaks.

9.4 *Limitations of the research*

As with predominately quantitative methods of studying grief, a qualitative approach has its own limitations. The liminal space of grief is without clear boundaries and the tools at my disposal captured only a small snapshot. However, as the aim of this research was not to reflect a true reality but destabilise existing claims, it has been my task to point towards alternative modes of thinking about grief that can enable further research with scope for employing more and different methods.

Focusing on any type of bereavement has its gains and shortcomings. I did not want to accept the existence of a 'hierarchy' of grief and reaffirm it by choosing one type of bereavement over another, and presume one form of bereavement would be more likely to predispose a person to complicated grief. I wanted to explore whether any form of bereavement can become complicated depending on an array of factors: practical, psychological and sociological. For example, in this thesis I did not want to claim the death of a child is the 'worst' form of bereavement. I wanted to give voice to those 'natural' bereavements too, of older people bereaved of their partner, which as revealed in Chapter 7, posed just as much distress for the bereaved person.

The absence of a particular type of bereavement on which to focus my research posed a methodological problem in deciding who to recruit. It also meant that the data gathered from the participants included in this study do not speak to a particular field of grief and bereavement research. However, in this thesis I have sought to actively

avoid making general claims about grief, and further to avoid the segmenting of grief experiences found in bereavement research. The search for generalisability and 'validity' in grief research has encouraged a need for scientific accuracy in studies of grief. However, I have argued that this search is reliant upon an unfounded assumption of the natural course of grief. I argue the 'natural' course of grief has been inextricably intertwined with 'normal' societal expectations of grief. The elaboration of universal claims to grief and grouping grief into types, I argue, has not lead to the 'truth' of the experience of grief but rather constructed further psychologically informed norms, epitomised in the psychological construction of 'complicated grief'.

A further limitation of this study, as described above, was my apparent 'failure' to find the 'complicated griever'. However, as explained much like my decision to not explore a particular type of bereavement, this limitation, meant I could examine how grief boundaries and categories were constructed. Further, it allowed me to identify how grief itself had been constructed, as a staged process for example, which was not so much a construction of reality but a construction framed by the methods used to study grief, facilitated by the expanding practice of what became known as bereavement care.

9.5 Implications for further research and practice

The debates around the 'medicalisation' of grief persist as the ICD drafts its eleventh edition with the inclusion of 'prolonged grief disorder' (PGD), suggesting the nature of bereavement care and practice will continue to evolve in the UK. Further research is required to track these changes as they take place on a political and policy level,

examining how bereavement care becomes situated in ongoing changes to mental health care. As PGD becomes a recognisable diagnosis it will be crucial to explore whether and how people come to receive a diagnosis of PGD, investigating the points of contestation that may arise in the act of diagnosis. It is not clear how people will respond to such a diagnosis, and whether people might come to embrace the label as a legitimate form of identification. Will a diagnosis of PGD enable people to make sense of difficult grieving experiences? Will people turn more towards medical understandings of grief rather than literature, poems and stories (as I described in Chapter 5)? Certainly contemporary researchers are actively pursuing the biological underpinnings of grief, undertaking neuroscientific studies to understand grief in terms of brain chemicals (O'Connor, 2005, 2012). The excitement around exploring neuroscience to help explain mental disorders suggests that the focus on the brain as supplying the answers to grief will only increase (Rose, 2013; Fitzgerald & Callard, 2014). The study of grief thus continues to be redefined, albeit from a scientific or professional point of view. Examining the views and experiences of the bereaved person will be crucial to understanding the implications of these developments, particularly those considered to be experiencing 'complicated' or 'prolonged' grief.

Furthermore, research needs to attend to the types of treatment people will undergo to 'recover' from PGD and complicated grief. There would need to be consistency across the bereavement care organisations in order to implement such treatment, a consistency, as described in Chapter 6, which is currently lacking. Drawing from my own data on bereavement care practitioners, an increasing emphasis on psychiatric diagnosis may serve to widen the gap between the therapeutic approach of a person-centred volunteer-delivered bereavement counselling service and a clinical model of bereavement care. This poses the wider question of who has responsibility over the

management of grief. The responsibility for 'complicated grief' is clearly situated in the hands of the professionals, and yet the emphasis on grief as 'natural' has meant historically, bereavement care has separated itself from a 'medical model'. I suspect that with the introduction and implementation of psychiatric diagnosis of PGD that the purpose and goals of bereavement care will become increasingly uncertain and divided.

I have argued my data show that psychological approaches have dominated the experience and recovery from grief, which consequently has reduced the possibility for other ways of understanding and managing grief. But further, I have questioned the need to manage grief in the first place. Drawing out the implications for practice from this thesis, therefore, rests on the hesitancy to make universal claims about grief and what should be done about recovering from it. Yet clearly there is a need to address individual and collective suffering in a modern western society such as in England, where its population arguably are experiencing conflict and confusion over how best to live with feelings of grief. The bereavement counsellors I met at Caris bereavement service presented a model of care that benefited by being an open-ended service that allowed for clients to 'work through' the difficulties of grief, and was facilitated by counsellors who were trained in a variety of approaches which meant grief was understood and dealt with from a wider perspective. While these factors enabled, in my view, a better approach within the already existing aims and intentions of bereavement counselling, this thesis has argued for a need to challenge and critique the constructed need and obligation to recover, around which therapeutic discourses and interventions also have been constructed to remedy.

Acknowledging the possibility of non-recovery from a practice perspective involves

acknowledging that the method *can* fail the person. Shifting responsibility away from the individual, and moving away from describing recovery as a result of the 'willingness' of the client, I argue is crucial for promoting a model of care in bereavement services, rather than a (superficial) over-emphasis on individual choice (Mol, 2008). To arrive at this point practitioners and the models they employ need to acknowledge that a failure to fit the model is not necessarily a failure to achieve recovery, or a form of resistance. Bereavement care practice needs to become aware of how managing grief is linked to societal norms and political and economic concerns that do not necessarily have the interests of the bereaved person at its centre. However, as I have demonstrated in this thesis the boundary between individual and political concerns is increasingly unclear, as contemporary government policy has continued to utilise a discourse of individual well-being, which in principle aims to place the individual at the heart of policy.

Only by acknowledging the ways in which recovery has become an obligation of the modern individual, along with an array of other modern demands such as maintaining happy emotions and being a hard-working citizen, can new ways of practicing, living and experiencing grief be considered. When recovery, completion and happiness are no longer positioned as the ever out-of-reach goal to which each individual is encouraged to desire and achieve, can bereavement care practice embrace the liminal space that grief can provide, rather than erasing it in the name of normalisation.

Appendices

1. Confirmation of ethical approval

1.1 The Open University Human Research Ethics Committee letter of approval

1.2 NHS National Research Ethics Committee Favourable Opinion (front page)

1.3 Cruse Research Group

1.4 St Christopher's Hospice Audit and Research Committee

2. Participant information sheet: Practitioner version

3. Participant information sheet: Client version

4. Consent form

5. Tables of participants

6. Interview schedule

From Dr Duncan Banks
Chair, The Open University Human Research Ethics Committee

Email duncan.banks@open.ac.uk

Extension 59198

To Caroline Pearce, FHSC

Subject *"When grief gets complicated: An ethnographic study into recovery following bereavement in the UK."*

Ref HREC/2014/1618/Pearce/1

Red form

Submitted 06 February 2014

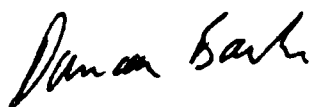
Date 10 March 2014

This memorandum is to confirm that the research protocol for the above-named research project, as submitted for ethics review, has been given a **favourable opinion** by the Open University Human Research Ethics Committee. Please note that the OU research ethics review procedures are fully compliant with the majority of grant awarding bodies and their Frameworks for Research Ethics.

Please make sure that any question(s) relating to your application and approval are sent to Research-REC- Review@open.ac.uk quoting the HREC reference number above. We will endeavour to respond as quickly as possible so that your research is not delayed in any way.

At the conclusion of your project, by the date that you stated in your application, the Committee would like to receive a summary report on the progress of this project, any ethical issues that have arisen and how they have been dealt with.

Regards,



Dr Duncan Banks

Chair OU HREC

The Open University is incorporated by Royal Charter (number RC 000391), an exempt charity in England & Wales and a charity registered in Scotland (number SC 038302)

HREC_2014-16180-Pearce-1-approval



Health Research Authority
National Research Ethics Service
NRES Committee London – Central
3rd Floor

Barlow House
4 Minshull Street

Manchester
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Telephone: 0161 625 7434

16 May 2014

Miss Caroline Pearce
PhD Student
The Open University
The Faculty of Health and Social Care, Room 37 Horlock Building
Walton Hall
Milton Keynes
MK7 6AA

Dear Miss Pearce

Study title:	When grief gets complicated: An ethnographic study into recovery following bereavement in the UK.
REC reference:	14/LO/0651
Protocol number:	NA
IRAS project ID:	149189

Thank you for your letter of 14 May 2014, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Shehnaz Ishaq, nrescommittee.london-central@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Appendix 1.3 Cruse Research Group ethical approval

From: Research [Research@cruse.org.uk]

Sent: Thursday, May 01, 2014 9:23 PM

To: Caroline.Pearce

Subject: WHEN GRIEF GETS COMPLICATED: AN ETHNOGRAPHIC STUDY INTO RECOVERY FOLLOWING BEREAVEMENT IN THE UK

Dear Caroline

The Research Group has considered your proposal and I am writing to inform you that your application has been approved. We note that the research will contribute to your PhD thesis and that you hope to find out how complications in grief recovery are managed and understood by both the person bereaved and by bereavement care and health care professionals. It is anticipated that you will focus your study appropriately, ie not replicating what is already known in the field already. Additionally, it is expected that you will have suitable boundaries in place to ensure the work is conducted in an ethical manner, and provision is available for therapeutic intervention, should any be necessary.

We note that you are wishing to use 10 people from Cruse; this sample being part of a bigger study sample comprising NHS practitioners and service users, independent counsellors and hospice workers. Cruse is able to disseminate information necessary to recruit staff members and volunteers working from branches the most local to your location in London, if you forward this on to us in due course. However, the matter of involving Cruse clients in research is currently under discussion so at the present time Cruse clients cannot be approached for research purposes.

Kind regards

Marion Wilson
Cruse Research Group

Appendix 1.4 St Christopher's Hospice Audit and Research Committee ethical approval

From: [REDACTED] <[REDACTED]@stchristophers.org.uk>
Date: Thursday, 25 September 2014 13:26
To: Caroline Pearce <caroline.pearce@open.ac.uk>
Cc: "[REDACTED]" <[REDACTED]@stchristophers.org.uk>, "[REDACTED]" <[REDACTED]@stchristophers.org.uk>
Subject: RE: Research registration form

Dear Caroline,

I am pleased to be able to inform you that the Audit and Research Committee at St Christopher's has agreed the hospice's participation in your study. There were one or two small queries regarding participant recruitment that Jan will discuss with you, but the group was supportive of your work and in due course would like to be made aware of your findings.

With my best wishes for your project,

Nigel

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When grief gets complicated: A qualitative study into recovery following bereavement in the UK.

Participant information sheet

Purpose of the Study

The aim of this research is to explore how people recover from grief following bereavement. This research is investigating bereavement care services in the UK and the experiences of people who have been bereaved. This project is being carried out as part of my doctoral research at The Open University.

Why have I been invited to take part?

This project is investigating how recovery from grief is facilitated by bereavement care practitioners

What does it involve?

A one-to-one interview which should last between one and one and half hours and will be tape-recorded if you are happy to do this. You may end the interview at any point if you wish. These are some of the areas to be covered at the interview:

- What approach do you take to grief and bereavement?
- What sort of treatments or therapies (if any) are typically used?
- In your own practice, what constitutes a successful recovery?
- What are the identifiable signs that someone is struggling to recover?
- What course of action would you take if a person is showing symptoms of struggling to recover from grief?

How will my information be kept confidential?

Each person that takes part in this study will be asked to sign a consent form. Your views and contributions will be treated confidentially. All materials will only be discussed with my supervisors Dr Carol Komaromy and Dr Sam Murphy (contact details at bottom).

Interviews will be tape recorded and transcribed. All names and identifying features will be anonymised and safely stored on password protected, encrypted computers. Any hard copies of information will be safely stored in locked cabinets. The data collected from this study will be anonymised and kept for up to 15 years and will be securely stored at all times after which all information will be destroyed.

What will happen if I don't want to carry on with the study?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Your participation is voluntary and you may withdraw from the study at any

point. If you withdraw following any interviews the data that you have contributed will be destroyed.

What are the possible benefits to taking part?

This research seeks to illuminate the role of practitioners in helping people recover from grief. Further this research aims to highlight the voice of the person who has been bereaved and their experiences of recovery.

Does this research conform to ethical guidelines?

This study has been approved on ethical grounds by The Open University Human Research Ethics Committee.

What will happen to the results of this study?

This research will contribute to my PhD thesis. I hope to publish my research in relevant journals as well as presenting my findings at conferences related to my topic area. The data collected may also be used for book chapters or a monograph. Direct quotations may be included in the publication of the research but no details of individuals or institutions will be identifiable.

Further information and contact details

I hope that you wish to take part in this research. Please do not hesitate to contact me if you would like to discuss any aspect of this research or require further information before agreeing to take part. I may be contacted by e-mail or phone, details of which are supplied below:

Name: Caroline Pearce

Address: Faculty of Health and Social Care, The Open University, Walton Hall, Milton Keynes, MK76AA

Email: caroline.pearce@open.ac.uk

Tel: [REDACTED]

Supervisors contact details:

Dr Carol Komaromy: Faculty of Health and Social Care, Walton Hall, The Open University, Milton Keynes, MK7 6AA.

Telephone no: [REDACTED] Email: [REDACTED]

Dr Sam Murphy: Faculty of Health and Social Care, Walton Hall, The Open University, Milton Keynes, MK7 6AA

Telephone no: [REDACTED] Email: [REDACTED]

Appendix 3 Participant information sheet: Client version

When grief gets complicated: A qualitative study into recovery following bereavement in the UK.

Participant information sheet

Purpose of the Study

The aim of this research is to explore how people recover from grief following bereavement. This research is investigating bereavement care services in the UK and the experiences of people who have been bereaved. This project is being carried out as part of my doctoral research at The Open University.

Why have I been invited to take part?

This project is interested in experiences of living with and recovering from grief.

What does it involve?

A one-to-one interview, which should last between one and one and half hours and will be tape-recorded if you are happy to do this. In the interview I will be asking questions about your experiences of grief and bereavement and feelings about recovery. You may end the interview at any point if you wish. During interview you are free to not answer any questions if you feel uncomfortable.

How will my information be kept confidential?

Each person that takes part in this study will be asked to sign a consent form. Your views and contributions will be treated confidentially. All materials will only be discussed with my supervisors Dr Carol Komaromy and Dr Sam Murphy (contact details at bottom).

Interviews will be tape recorded and transcribed. All names and identifying features will be anonymised and safely stored on password protected, encrypted computers. Any hard copies of information will be safely stored in locked cabinets. The data collected from this study will be anonymised and kept for up to 15 years and will be securely stored at all times after which all information will be destroyed.

What will happen if I don't want to carry on with the study?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Your participation is voluntary and you may withdraw from the study at any point. If you withdraw following any interviews the data that you have contributed will be destroyed.

What are the possible benefits to taking part?

This research seeks to highlight the unheard stories of bereavement and your experiences of recovering from grief.

Does this research conform to ethical guidelines?

This study has been approved on ethical grounds by The Open University Human Research Ethics Committee.

What will happen to the results of this study?

This research will contribute to my PhD thesis. I hope to publish the research in relevant journals as well as presenting my findings at conferences related to the topic area. The data collected may also be used for book chapters or a monograph. Direct quotations may be included in the publication of the research but no details of individuals or institutions will be identifiable.

Further information and contact details

I hope that you wish to take part in this research. Please do not hesitate to contact me if you would like to discuss any aspect of this research or require further information before agreeing to take part. I may be contacted by e-mail or phone, details of which are supplied below:

Name: Caroline Pearce

Address: Faculty of Health and Social Care, The Open University, Walton Hall, Milton Keynes, MK76AA

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Supervisors contact details:

Dr Carol Komaromy

Faculty of Health and Social Care, Walton Hall, The Open University, Milton Keynes, MK7 6AA.

Telephone no: [REDACTED]

Email: [REDACTED]

Dr Sam Murphy

Faculty of Health and Social Care, Walton Hall, The Open University, Milton Keynes, MK7 6AA

Telephone no: [REDACTED]

Email: [REDACTED]

Consent form

Name of Project: When grief gets complicated: A qualitative study into recovery following bereavement in the UK.

Name of Project Researcher: Caroline Pearce

Please read the following and sign.

I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

I understand that my participation is voluntary and that I can withdraw at any time without giving any reason.

I have been assured that my confidentiality will be protected as specified in the information sheet.

I agree that the information that I provide can be used for educational or research purposes, including publication.

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Name of participant	Date	Signature

Table 1 Bereavement care professional participants

Name	Identifier	Role	Organisation
Wendy	BC1	Bereavement service counsellor/coordinator	Caris Islington bereavement service
Linda	BC2	Bereavement service counsellor/coordinator	Caris Islington bereavement service
Daniela	BC3	Bereavement counsellor	Caris Islington bereavement service
Matthew	BC4	Bereavement counsellor	Caris Islington bereavement service
Claire	BC5	Bereavement counsellor	Caris Islington bereavement service
Kelly	BC6	Bereavement counsellor	Caris Islington bereavement service
Sarah	EIP1	Early Intervention Project Manager	Cruse
Jane	EIP2	Early Intervention Project volunteer	Cruse
Susan	BSW1	Bereavement support worker	Cruse
Marion	BSW2	Bereavement support volunteer	St Christopher's Hospice, Bromley
Tony	BC7	Trauma counsellor, Senior supervisor for hospice bereavement service	BACP St Christopher's Hospice, Bromley
Ellen	GRM	Managing Director	Grief Recovery UK
Pamela	BSC	Bereavement service coordinator	Local bereavement service in Lewisham, South-East London

Table 2 Bereaved participants

Name	Age at interview (yrs.)	Type of bereavement	Length of bereavement
Anne	46	Husband fell out of a window	4 years
Tania	41	Husband died of sudden brain haermorrage	2 years
Laura	51	Husband died suddenly of ruptured aorta	2.5 years
Saadhia	32	Mother died after long illness	4 years
Jamie	34	Sister died in accident when he was 16 Mother died when he was 24	18 years 10 years
Paul	64	Wife died after long illness	1 year
John	63	Wife died of cancer	9 months
Rose	63	Husband died of heart attack	26 years
Helen	64	Grandfather when 7 years old Parents later in life	57 years

Table 3 Participants from mental health services

Name	
Eva	Ex-mental health service user. Former Recovery College peer worker
David	Current mental health service user
Donna	Worked on women’s suicide crisis help line

Interview schedule - Practitioners

What approach do you take to grief and bereavement?

- Is your approach to practice influenced by any theories and perspectives?
- How do these affect your practice?

What sort of treatments or therapies (if any) are typically used in your practice?

- What is the goal/aim of each treatment?
- Do treatments vary from each individual patient and in what ways?

In your own practice what constitutes a successful recovery?

- What are the identifiable signs and symptoms of a successful recovery?
- Can recovery be measured, and if so how?

What are the identifiable signs and symptoms that someone is struggling to recover from grief?

- Are these psychological, somatic or social/environmental symptoms or a combination of all three?
- What are the psychological symptoms?
- What are the somatic symptoms?
- What are the social/environmental factors?
- Is the length of time from bereavement significant?

What course of action would you take if a person is showing symptoms of struggling to recover from grief?

- Ask for examples
- When is referral necessary?
- Are there instances in which it is necessary to diagnose bereaved patients, for example as having a form of complicated grief, depression or anxiety disorder?

Interview schedule - service users/clients

Can you tell me about your experiences of using (name of mental health/bereavement) service?

Did you (a) seek out help independently or were you (b) referred by a GP/healthcare professional for further support?

a) When did you seek help for dealing with your grief?

- Can you explain what influenced your decision to seek out help and support?

b) When were you referred for mental health/bereavement services?

- Why were you referred to mental health/bereavement services?
- Who referred you?
- How did you feel about being referred?

What sort of activities have you been involved in to help manage your feelings of grief?

- In what ways do you feel this involvement affected your experience of grief?

What types of therapies (if any) have you received?

- In what ways do you feel the therapy has affected your experience of grief?

What sort of treatments (if any) have you received?

- In what ways do you feel this treatment has affected your experience of grief?

Have you received a clinical diagnosis, for example, complicated grief, depression or anxiety disorder in the course of being treated and/or receiving care for your grief?

- (if yes) What were the reasons for this decision?
- Who made the diagnosis?
- (if no) Do you think that there is (or has been) a situation where such a diagnosis would be helpful to you?

From your own experience what do you think constitutes a successful recovery from grief?

What are your feelings about the term 'recovery'?

Do you feel recovery should involve help or intervention from bereavement care professionals?

- If yes - In what ways?
- If no - What sort of role should they play (if any)?

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